The land of milk and honey

A picture of refugee torture survivors presenting for treatment in a South African trauma centre

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Abstract

Intake data obtained from 55 refugee torture survivors accessing trauma treatment services at a centre in Johannesburg, South Africa, paints a picture of suffering beyond the torture experience. The intake forms part of a more comprehensive monitoring and evaluation system developed for the work done with torture survivors accessing psychosocial services. The diverse sample with different nationalities highlights that torture occurs in many countries on the African continent. It also highlights South Africa's role as a major destination for refugee and asylum seekers. However, "the land of milk and honey" and the process of arriving here, often poses additional challenges for survivors of torture. This is reflected in the high levels of Post Traumatic Stress Disorder (69%), anxiety (91%), and depression (74%) for our sample, all of which were significantly correlated. The loss of employment status from before the torture experience until the time of intake was great for this sample, impacting on their recovery. In addition the presence of medical conditions (44%), disabilities (19%), and pain (74%) raise serious questions regarding interventions that focus mainly on psychosocial needs. No significant gender differences were found. The paper begins to paint a clearer picture of the bio-psycho-social state of torture survivors accessing services in South Africa, as well as highlighting many of the contextual challenges which impact on recovery.

Key words: torture; PTSD; refugees; South Africa; trauma

South Africa

The history of violence in South Africa has spanned decades. Tribal wars are part of the historic landscape which was forever affected by colonialism and the subsequent system of Apartheid. Apartheid made use of institutionalized and systematic violence to place the control of the majority of the population in the hands of a white minority. The subsequent transition to democracy in 1994 has been characterized by high levels of violent crime which, although on the decline, persist up until today. Indeed, the statistics released by the South African Police Service (SAPS) put the number of reported contact crimes at 685,185 in 2008/2009[1] (1407.4 per 100 000 of the population or 1,877 per day), including murder, sexual offences, attempted murder, assault with the intent to inflict grievous bodily harm, common assault, robbery with aggravating circumstances, and common robbery.

Refugees in South Africa

Refugee and asylum seekers are not immune to this and violence against foreign-

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ers continues to occur. Once within South African borders, asylum seekers are exposed to violent crime and xenophobic attacks, as was seen in 2008. The xenophobic violence was characterised by the attack, or threat of attack, on non-nationals living in townships and informal settlements located within the main urban settings of Gauteng and the Western Cape. Estimations of the total number of people displaced due to these attacks range between 80,000 and 200,000.[2] Between 25,000 and 35,000 Mozambicans and Zimbabweans fled South Africa at this time.

Although South African Law guarantees all people basic civil and political rights, regardless of their nationality or legal status,[3] the necessary human and financial resources needed to offer basic protections to asylum seekers and refugees have not been made available. Torture survivors among this group of refugees have even more challenges to contend with. Broad statistics do not capture the individual experiences that are so important within clinical practice. For this reason two vignettes from recent cases are presented here. Names and other identifying information have been changed to protect the identity of our clients.

Samuel is a Movement for Democratic Change (MDC) supporter from Zimbabwe who reported being tortured on three occasions, experienced internal displacement, and had his property destroyed. He could no longer make a living and was forced to flee to South Africa. In South Africa, he was exploited by a construction company who refused to pay him for work done before he obtained his asylum seeker document. Since arriving in South Africa he has been a victim of two serious violent crimes. He was robbed at gun point and then kidnapped by people posing as customers for his business. The kidnappers drove him around in their car demanding money that he did not have. Fortunately, he managed to jump out when the car came to a stop and flee. More recently, while working as a security guard, he has witnessed many other violent events. He has been unlawfully arrested for loitering while crossing a park on his way home from shopping and forced to pay a bribe for his release. He has also been the victim of petty thefts in the unsafe accommodation that poverty forces him to share.

Maria is a professional from Central Africa who was severely tortured by rebel groups and by government officials while in detention. Her husband and other family members were killed as punishment. She fled to South Africa with her two small children. A month after her arrival xenophobic violence broke out where she was living. She became suicidal during this time. She has been contacted and threatened repeatedly by officials from the Democratic Republic of the Congo (DRC) and fears for her life here in Johannesburg. Maria has had many problems renewing her asylum document each month. She sleeps overnight with her children at the office of Home Affairs so as to get a place in the queue the following morning, but is often shifted to the back for not paying a bribe. One night armed robbers attacked the people in the queue, most of whom fled screaming in different directions. This experience retraumatized her, because it reminded her of the attack by the rebels in the DRC. She explained that the affected asylum seekers were offered shelter inside the Home Affairs building for the night, but only in exchange for a bribe. Maria does casual jobs cleaning and cooking in a crèche. She has been living in an unsafe shared house where she cannot control who enters and exits the property and whether the doors and gates are locked or not.

Samuel and Maria's stories illustrate

some of the challenges and complexities that asylum seekers in South Africa face. It is important that service providers understand these complexities deeply in order to provide effective care and support.

Centre for the Study of Violence and Reconciliation, Trauma and Transition Programme

The Centre for the Study of Violence and Reconciliation (CSVR) is a multi-disciplinary institute whose primary goal is to use its expertise to build reconciliation, democracy and a human rights culture, and to prevent violence in South Africa and in other countries in Africa. The Trauma and Transition Programme (TTP) of the CSVR aims to sustain democracy by addressing the issues of unresolved trauma, torture, criminal violence and forced migration through psychosocial support, research and advocacy in South Africa and the continent.

TTP was set up in 1989 to offer a free counselling service to victims of political violence. Since the mid-1990s there has been a shift from political violence to criminal violence within the country. From the late 1990s, TTP began counselling refugees and asylum seekers, individuals and groups from various African countries who had experienced violent conflict in their home countries and/or xenophobic violence in South Africa.

With the support of the Rehabilitation and Research Centre for Torture Victims (RCT), TTP has embarked on a project aiming to strengthen the struggle against torture in South Africa and the African region. One of our objectives is to develop a comprehensive Monitoring and Evaluating (M&E) system for the psychosocial services provided to victims of torture. These services include: counseling; interpretation; support with referrals to other organisations; and assistance with information regarding asylum/refugee application processes. The aims of M&E include the creation of spaces for reflection and learning, and it is hoped that this process will help us learn more about our interventions and assist clinicians in improving services to victims of torture.

Evaluation methodology

The data presented here is part of a more comprehensive M&E process initiated in mid 2007. The development of all M&E instruments and the system itself was informed by current theory and achieved through collaboration between clinical staff, researchers, external consultants, and RCT staff. The system has changed over time to accommodate challenges encountered through implementation. The intake is aimed at providing detailed information for clinicians to guide their interventions, and to establish a baseline of each client's functioning against which progress can be measured. In the end, the intake form included demographic information; the Harvard Trauma Questionnaire;[4] The Hospital Anxiety and Depression Scale (HADS);[5] several questions which emerged from the International Classification of Functioning, Disability and Health (ICF)[6] as well as questions regarding medical conditions, disabilities, pain, and substance use.

Questions relating to the ICF indicators were developed by having clinicians identify which indicators are most relevant to torture survivors. These were then prioritized as a way to reduce the list of indicators to a manageable number. Once certain indicators were agreed upon, the research team developed questions relating to these indicators. For example, clinicians indicated that under Support and Relationships of Environmental Factors of the ICF, indicator E355 – Health Professionals should be included. According

to the ICF "This chapter is about people or animals that provide practical physical or emotional support, nurturing, protection, assistance, and relationships to other persons, in their home, place of work, school or at play or in other aspects of their daily activities. The environmental factor being described is not the person or animal, but the amount of physical and emotional support the person or animal provides.". In line with this the following question was developed:

In general, do health professionals support or slow down your recovery at the moment? (E355):

(1) Slow down a great deal
(2) Slow down a little
(3) They have no impact on my recovery
(4) Support a little
(5) Support a great deal
(9) N/A or unknown

The data was derived from a newly developed system of M&E. In the beginning data capture was limited but this did not prevent clinicians from seeing clients. Over time, with capacity building and changes in organisational culture, levels of data capture are increasing. However, instruments have not been standardized for this population.

All non-South African adult clients that completed the intake from the beginning of the M&E project (April 2007) until the time of writing this paper (October 2009) and who reported a history of torture were included in the sample. All clients gave written informed consent to participate in the M&E process. Clients were free to refuse to participate and were not penalized if they so chose. In order to ensure that clients are supported and able to complete the intake, a number of steps have been taken. Clients first attend a counselling session before completing the intake. This allows the client to receive support immediately. The clinician explains the M&E process and sets up the intake before the following session. Intakes are done either by clinicians or by Psychology Masters students who have received additional training on the assessment and support of torture survivors. All information in the M&E was captured with client codes so that the research team did not have access to identifying information. This allowed us to maintain both confidentiality and anonymity.

Introducing data gathering systems into clinical practice is challenging and takes time. Nevertheless, it offers important possibilities for improving clinical practice through structured analysis and reflection.

Sample

A total number of 55 clients were included in the sample. Of these, 39 (71%) were referred to TTP by an external person or organization.

Clients came from eight different countries with the majority coming from Zimbabwe (Figure 1).

The sample was closely divided along gender lines, 29 women (53%) and 26 men (47%). The oldest client was 54 years of age

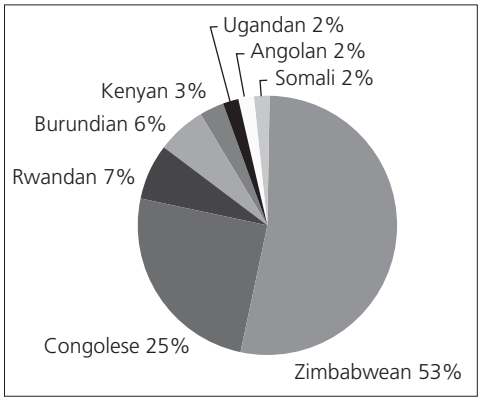

Figure 1. *Nationality.*

while the youngest was 19 at the time of intake. The majority of clients were between the ages of 22-47 (86%). Mean age for the sample was 34 with a standard deviation of 9.10.

Almost half of the clients (24) reported being married at the time of intake (Table 1).

Most clients (35%) were living with their family (which includes living alone with their children). Others were living with friends (19%); in a shelter (21%); alone (9%); with strangers (7%); or with their partner/spouse (6%). The majority of clients (70%) had children. Most of these had two children, while three clients reported having 6 children. Mean number of children was 2 with a standard deviation of 1.76.

Before the torture experience, the majority of clients were employed within skilled or highly skilled jobs. However, at the time of intake most were unemployed (Table 2).

Table 1. *Marital status.*

Marital status	Frequency	%
Currently married	24	44
Never married	18	32
Separated	2	4
Widowed	11	20
Total	53	100

Table 2. *Changes in employment status linked to torture.*

	Pre-torture employment %	Current employment %
Highly skilled/professional	29	0
Semi-skilled	16	6
Skilled	16	4
Student	13	2
Unemployed	15	70
Unskilled labour	9	18
Other or missing	2	0
Total (n=46)	100	100

Results

Psychiatric considerations

The Harvard Trauma Questionnaire (HTQ) provides three scores: a Total Score; a DSM-IV Post Traumatic Stress Disorder (PTSD) Score, and a Self-Perception of Functioning Score. The Harvard Program in Refugee Trauma (HPRT) which developed the instrument, offer no cut-off score for the Total Score, rather saying that the higher the total score, the more likely it is that the respondent has symptoms specifically associated with trauma. Functioning Scores also do not have cut-off values but the HPRT recommend that these be used as a rough guideline for the clinician in assessing the respondent's overall capacity to meet the challenges of everyday life. Self-Perception of Functioning Scores can range between 1 and 4, with a higher score indicating a more negative self-perception of functioning. In terms of the PTSD score a cut-off of 2.5 for being checklist positive for PTSD is recommended. The HTQ was specifically developed for conflict-affected populations and has demonstrated good psychometric properties in many African countries.[7] Using cut-off scores in screening is problematic.[8, 9] For different cultures HPRT recommend lowering the cut-off point to 2. However, this has the effect of potentially introducing many false positives and pathologising people. Therefore, we have chosen to keep the generally used cut-off scores, knowing that this is not a perfect solution.

For our sample, the mean HTQ: Total Score was 110.13, (standard deviation = 26.78). The mean Self-Perception of

Functioning Score for our sample was 2.69 (standard deviation = 0.68). The group presented with a mean score of 2.88 for PTSD (standard deviation = 0.67), with 38 people (69%) being checklist positive for PTSD.

The HADS takes 2 to 5 minutes to complete and provides a score for depression and a score for anxiety. For either subscale a score of 0 to 7 could be regarded as being in the normal range, a score of 11 or higher indicating probable presence of the mood disorder and a score of 8 to 10 being just suggestive of the presence of the respective state. This instrument has also been tested in many contexts and found to have good reliability and validity.

The results for this group in terms of anxiety and depression (n=54) are represented in Table 3.

The mean score for anxiety was 14.91 (standard deviation = 4.63) while the mean score for depression was 13.26 (standard deviation = 4.33). The correlation between anxiety, depression and PTSD using Pearson's Correlation can be seen in Table 4 (n=52).

Table 3. *Hospital anxiety and depression scale scores.*

	Anxiety %	Depression %
Normal	7	7
Borderline	2	19
Clinical	91	74
Total	100	100

Impact of environment (ICF indicators)

Questions were developed based on the ICF which look at the impact of authority figures (such as police officers and Home Affairs officials); health professionals and family members. Later on, due to the developmental nature of this project, the M&E team introduced further questions relating to functioning, based on ICF indicators. These questions related to learning and applying knowledge; ability to manage tasks and demands; and interpersonal interactions and relationships. Although the data set is more limited (n=20), these results provide a more nuanced picture of torture survivor's functioning, and have been included with the rest of the data.

When asked about the impact of authority figures on their recovery (n=50) 29 clients (58%) reported that authority figures slow down recovery (a little or a great deal). 22 (43%) and 11 people (21%) of our sample reported some form of harassment from the Department of Home Affairs (the Government department responsible for approving refugee status) or the Police respectively. This is illustrated in the following quote, "I got arrested by a police constable on the streets finding a job to sustain myself. I had two hundred Rands in my pocket which I lost to this constable because I was found without any legal document which permits me to stay here in South Africa." 26 people (59%) reported (n=44) that health professionals support their recovery (a little or a great deal), while 26 people (59%) reported that family

Table 4. *Correlations between PTSD, depression and anxiety scores*

	PTSD and depression	PTSD and anxiety	Anxiety and depression
Pearson's Correlation	r=0.71 p=0.0000	r=0.80 p=0.000	r=0.72 p=0.0000

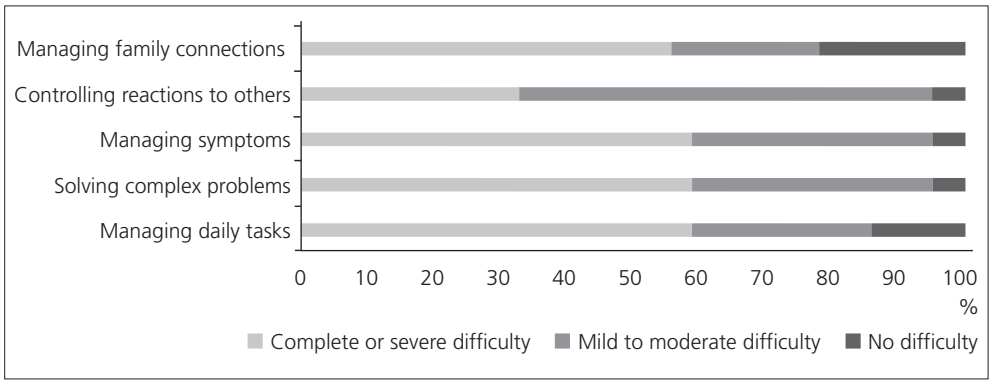

Figure 2. *Key dimensions of functioning.*

Table 5. *Correlation between functioning scores and psychiatric scores.*

	Depression	Anxiety	PTSD	Self-perception of functioning
Solving complex problems	n=22 R=0.3589 p=0.1009	n=22 R=0.4077 p=0.0597	n=22 R=0.4953 p=0.0190	n=22 R=0.5852 p=0.0042
Managing daily tasks	n=22 R=0.6925 p=0.0004	n=22 R=0.6244 p=0.0019	n=22 R=0.6822 p=0.0004	n=22 R=0.6809 p=0.0005
Managing symptoms	n=22 R=0.5903 p=0.0038	n=22 R=0.5735 p=0.0053	n=22 R=0.6207 p=0.0020	n=22 R=0.5579 p=0.0070
Controlling reactions to others	n=21 R=0.3527 p=0.1168	n=21 R=0.5558 p=0.0089	n=21 R=0.5562 p=0.0088	n=21 R=0.5563 p=0.0088
Managing family connections	n=18 R=0.1719 p=0.4952	n=18 R=0.1852 p=0.4619	n=18 R=0.0886 p=0.7264	n=18 R=0.2128 p=0.3966

members support their recovery (a little or a great deal).

When asked questions regarding functioning the following answers were forthcoming (Figure 2).

Functioning and psychiatric conditions

An analysis of the correlations between the functioning scores and the psychiatric scores is displayed in the table below. Measures of functioning were not normally distributed; therefore the non-parametric Spearman's Rank Coefficient was used. All functioning scores except managing connections with family were significantly correlated to one or more psychiatric conditions. Furthermore, managing daily tasks and managing symptoms are significantly correlated with all for psychiatric scores, namely depression, anxiety, PTSD, and self-perception of functioning.

Table 6. *Categories of medical conditions reported.*

Category of self-reported medical condition	Incidence	Due to Torture
Respiratory Problems	5	3
Emotional difficulties	6	4
Problems with eyes	5	3
Difficulties in the neck or head area (including headaches, and ear or neck problems)	4	3
Problems with teeth	4	3
Pain/problems in the back, ribs, or abdominal areas	9	7
Pain in feet or legs	3	3
Circulatory difficulties	3	1
Other (2)	2	2
Total (41)	41	29
Total	100%	71%

Physical health

Clients were asked if they suffered from any medical conditions, disabilities and pain. If they responded yes, they were asked if this was due to their torture experiences. 24 clients (44%) reported suffering from a medical condition. A broad range of medical conditions were reported including restlessness, depression, neck and head aches, eye related problems, dental problems, foot pain, anemia, difficulty urinating, high blood pressure and heart palpitations. Table 6 provides information on the categories of medical conditions experienced as well as their link to the torture experience.

10 people (19%) reported suffering from a disability all of whom reported that it was due to the torture they had experienced. Most (60%) reported a disability in the head or neck region. The majority of the sample (40 people or 74%) reported experiencing some form of pain. Of the 79 incidences of pain reported, 66 (84%) said the pain was due to torture. The areas of pain are outlined in Table 7.

Table 7. *Areas affected by pain.*

Pain	Incidence	Due to torture
Shoulder region	9	8
Upper extremity	6	6
Genital pain	2	2
Abdomen	11	9
Chest pain	8	6
Lower extremity	15	12
Head and neck	21	17
Generalised pain	2	2
Back pain	5	4
Total	79	66
Total	100%	84%

Despite the high incidence of medical conditions, disability and pain reported by the sample, only nine clients indicated that they were taking prescription drugs. Reported use of substances such as cigarettes, beer, wine, and spirits was very low for this sample with 84%, 80%, 80% and 90%

respectively saying they do not use any of these substances.

Discussion

According to the Office of the United Nations High Commissioner for Refugees (UNHCR) 2007 Global Trend Report,[10] approximately 67 million people around the world had been forcibly displaced by the end of 2007. South Africa had the second highest number of new claims for refugee status in 2007, namely 45,600. In fact, since 2002, South Africa has received more than 251,000 individual asylum applications, making it one of the largest recipients in the world. Although South Africa is a favoured destination for people seeking refuge, serious challenges face asylum seekers within the country. South Africa had a total asylum case backlog of over 89,000 cases in 2007.[11] Often, asylum seekers are forced to wait several years before they are informed on whether or not they are to receive refugee status. A large number of asylum seekers are from Zimbabwe, with 85% of all Zimbabwean asylum requests being lodged in South Africa.[12] The number of unconfirmed estimates of Zimbabweans in South Africa is between one and nine million.

Survivors of torture accessing our services present with a complex clinical picture which is continually impacted by contextual challenges. This paper is based on a clinical sample and therefore not representative of refugee torture survivors generally. We know that many clients accessing our services are somewhat aware of what services we provide because the majority (75%) of our sample were referred to us by an outside individual or organisation. The high influx of Zimbabweans and the high levels of human rights violations (including torture) reported there are clearly reflected in our sample which includes a large percentage of Zimbabweans. A recent report profiling human rights violations and torture in Zimbabwe,[13] indicates that since July 2001, 40,559 human rights violations have been reported to the Zimbabwe Human Rights Non-Governmental Organisation Forum. The data indicates an increase in reports of torture from 136 cases in 2005 to 723 cases in 2008. The report also compares reported violations in "election" and "non-election" months. The number of reports in "election months" is significantly higher than in "non-election" months, clearly demonstrating the political factors contributing to millions of Zimbabweans fleeing into South Africa.

The literature suggests that men are more likely to report torture than women. In contrast to this, this sample is evenly divided between men and women. This may be linked to women being more likely than men to seek assistance.

The sample was almost equally divided in terms of those who were married and those who had never been married, were widowed, or separated. The ages of the majority of clients indicate a group of people at a stage of their lives where they should be the most productive. This raises questions regarding the impact of the torture on their ability to access and obtain resources, in the short to long-term. 37% of the sample have what could be considered "vulnerable" living conditions, with strangers, alone or in a shelter. 38% reported living with their families, which could include single parents living alone with their children. This population group is a particularly vulnerable one within South Africa. The South African Government does not presently maintain refugee camps. Herman[14] highlights the need for securing safety prior to trauma treatment. Given the vulnerable living conditions in which our client group works, the question of what can and cannot be dealt with within the therapeutic space becomes a

central clinical consideration. The majority of clients reported having children, which could burden them additionally with addressing current needs as well as coping with the prior torture experience. Some of these clients had to flee without their children, creating yet another stressor.

Changes in employment status from before and after the torture experience are significant. These changes may not be completely linked to the torture experience but could speak to the change in context experienced. Because many are asylum seekers, securing employment can be difficult, due to xenophobic sentiments as well as difficulties obtaining legal status. The loss in employment and corresponding income could influence clients' ability to cope with their experience of torture. This loss in status could also impact on self-esteem, with survivors no longer feeling that they are able to provide for themselves and/or their families.

Besides these difficulties, refugees face many ongoing challenges, including the fear of being arrested, persecuted or tortured if they return to their home countries, living with a history of discrimination, being traumatized by the migration process (especially those who entered host countries unlawfully), living in poor neighborhoods, being alone, not knowing the culture or language of the host country, and living in a host country that in some way may have supported the regime responsible for their persecution.[15]

The average Self-perception of Functioning score for our sample indicates a poor perception of their ability to function. The gender differences on this score are not significant but do indicate that male torture survivors may have a slightly more negative perception of their capacity to meet the challenges of everyday life. Men could be placing more pressure on themselves to cope with the difficulties of their new situation. It is likely that being unable to provide for one's family has a greater impact on perception of functioning for men than for women. In addition, services for refugees in South Africa tend to prioritise women and children. This may have the unintended result of further marginalizing and disempowering men as well as fragmenting refugee families.

Studies have found varied PTSD rates in survivors of torture. According to Johnson and Thompson,[16] PTSD prevalence in refugee torture victims ranges from 14 to 92%. Masmas et al. found a 63% PTSD rate among tortured newly arrived asylum seekers in Denmark.[17]

High levels of PTSD within our sample reflect the extremely vulnerable situation in which people accessing our services find themselves. Not only have they suffered torture but many may have been exposed to other traumas since the torture experience. Securing safety within the South African context is hardly possible, thereby increasing vulnerability for PTSD. No major gender differences emerged in terms of PTSD scores.

The majority of clients were checklist positive for both depression and anxiety, making the clinical picture even more complex. Depression has been strongly linked with PTSD[18] and the strong correlation between the two in our sample clearly highlight the complexity of these cases. It also highlights the need for pharmacological intervention for this group. Given the experiences of our sample it is not surprising that they score significantly higher in terms of depression.

The results show that many clients felt in some way supported by their family and/or by health professionals. When asked about people in positions of authority, however, the results were reversed. Over half the sample

felt that people in positions of authority slowed down their recovery. Indeed, clients do report instances of harassment by police officials and poor treatment at refugee reception offices. When people are still exposed to threats, recovery from PTSD and other disorders is likely to be compromised. External factors impact on the client's state. This information can also assist clinicians to identify, reinforce, and expand support structures to areas where clients have additional identified needs, and to raise awareness and promote advocacy within police forces, health officials and those who are responsible for asylum determination.

The majority of clients reported having mild or moderate difficulties in managing daily tasks and solving complex problems. The majority of clients reported difficulty in managing their symptoms and controlling their reactions to others. This will clearly impact on their ability to function in society and gain access to resources or services they need. Clients were equally divided between "no difficulties" and "some" or "severe" difficulties in relation to their connections with their families. This may be linked to difficulty in communicating with family members who remained in the country of origin. This information provides clinicians with a better sense of where a client's strengths and weaknesses may be within the area of every day functioning. Given the complex contextual stressors many torture survivors in South Africa encounter (discussed above), it is no surprise that their ability to function is frequently negatively impacted.

Analysis of the links between functioning and dysfunction scores shows that psychopathology is related to a loss of functioning. It is interesting to note that anxiety disorders are particularly associated with loss of functioning in multiple spheres whereas depressive symptoms, while impacting on management of daily tasks and disruptive symptoms, do not impact on problem solving and reactions to others. Tortured refugees reported that their functioning within family networks was largely unaffected by their symptoms.

Health and mental health needs have been shown to be the highest priority for torture survivors.[19] Leidl and Knaevelsrud[20] highlight the link between pain and PTSD and how this plays a role in treatment. The wide array of medical conditions, disabilities and pain reported by the sample, primarily related to their experiences of torture, highlights the need for medical care as part of any intervention. Physical impacts may continue to reduce a client's ability to recover and cope, but accessing medical care may also be problematic for this group.

Indeed, Higson-Smith's study, which explored exiled torture survivors' torture related needs and experiences of health services in Johannesburg highlighted health-related difficulties. The study indicated that far fewer than those who had listed significant and chronic symptoms or were in need of health care had actually received any care through the South African health services. This may be linked to discrimination and even abuse at the hands of health personnel, negatively impacting on recovery. In fact, respondents in the 2007 study rated the level of health care facilities in South Africa highly, but rated health care providers poorly. The report highlights incident after incident in which tortured exiles were turned away from health institutions or were badly treated. The line between physical and psychological treatments becomes blurred when working with victims of torture, and as such it becomes impossible to work therapeutically without attending to the physical difficulties experienced by clients.

Conclusion

The M&E system developed and established within TTP of the CSVR provides clinicians with information regarding torture survivors accessing their services. In order to provide better services it is central that clients are assessed in a systematic way. This process provides us with information that clearly influences treatment options and strategies. It highlights areas of concern in terms of functioning and points to ways in which clients function well.

The data obtained paints a complex clinical picture of refugee torture survivors accessing services in what some refer to as "the land of milk and honey". It highlights some of the contextual factors that negatively impact on the recovery process of this group, which clinical interventions will need to take into consideration. It is clear that therapeutic work with refugee victims of torture in South Africa is complex and the extreme contextual factors will impact on clinical interventions provided.

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