Group treatment for survivors of torture and severe violence: A literature review

Mary Bunn, MA*, Charles Goesel, MA, PhD Candidate**, Mélodie Kinet, MPH, MBA***, Faith Ray****

Abstract

Methods: The authors conducted a systematic review of scholarly journals and manuscripts. The search was limited to articles published in English that focused on group treatment with torture survivors.
Findings: The authors identified 36 articles and chapters for review describing a variety of group interventions for survivors of torture, including:

- Supportive Group Therapy
- Empowerment Workshops
- Group Treatment for Sleep Disorders
- Den Bosch model
- Wraparound approach
- Stage-oriented model

The literature examined varied in approach and format: present-day and past-focused groups; structured, time-limited groups; and flexible, ongoing support groups. The studies took place in diverse locations, including Denmark, Germany, Guinea, Namibia, the Netherlands, Palestine, Serbia, the U.S., the UK, and Zimbabwe, and, in conflict, post-conflict and/or humanitarian settings. The interventions were facilitated by licensed mental health professionals, paraprofessionals, and bilingual/bicultural staff – or a combination of the latter two.
Interpretations: Group treatment is an approach which can be administered to larger groups of survivors to address a range of treatment issues. The authors examined key clinical practice issues for group treatment including group composition and content, facilitation and measurement strategies. While the literature does provide a compelling conceptual rationale for using group treatment, the empirical literature is in fact very limited at this time, and needs to be strengthened in order to build confidence in outcomes across contexts and survivor communities.
Conclusions: This paper points to a growing interest in the topic of group treatment for survivors of torture and severe violence, providing a comprehensive picture of group-based interventions and highlighting the need for additional research and knowledge-building.

Keywords: group, treatment, torture, therapy

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*) University of Chicago School of Social Service Administration and Heartland Alliance International
**) National Partnership for Community Training at Gulf Coast Jewish Family and Community Services
***) National Partnership for Community Training at Gulf Coast Jewish Family and Community Services
****)National Capacity Building Project at Center for Victims of Torture, Chicago, Illinois, USA

Introduction

"Sharing the traumatic experiences with others is a precondition for the restitution of a meaningful world."[1]

The use of torture is a pervasive and pressing problem around the world. Amnesty International[2] reported that at least 112 countries are estimated to utilize forms of torture against their citizenry. A recent meta-analysis by the Center for Victims of Torture[3] suggests that there may be as many as 1.3 million torture survivors currently living in the United States. The consequences of torture extend well beyond the reach of the individual survivor and have a deeply polluting effect on society as a whole. As Mpande and colleagues[4] said when referring to torture and violence in South Africa, "Actions, both violent and intimidating, are intended to create a polarized and dysfunctional society. Violence and conflict affect the way people relate to each other, the way organizations function, and their relationships. Families fragment and support structures become less effective, or even become sources of terror and violence" (p.198).

In addition to mental health symptoms such as Post Traumatic Stress Disorder, anxiety, and depression,[5-11] as well as migration and resettlement issues, such as acculturation, under- or unemployment, and unstable housing, among other issues, torture survivors describe a number of social and interpersonal problems. This often includes a sense of social dislocation, loss of trust in others, and grief resulting from the loss of meaningful roles and connection to community.[1, 5, 8, 11-17] Group treatment has been described as a promising approach for reducing trauma-related symptoms and uniquely suited to address and foster positive changes in social and interpersonal wellbeing.[1, 5, 7, 8, 11, 12, 17-20]

The main purpose of this article, therefore, is to examine the literature on group therapy models for torture survivors. As will be discussed in greater depth, the literature on group treatment for torture survivors is limited at this time, with a predominance of pieces on clinical practice. This review is therefore primarily intended for practitioners who are working with torture survivors in exile or in resettlement. As part of our analysis, we consider key practice issues in the literature including the rationale for group treatment and approaches to and outcomes associated with group-based interventions. Although few in number and arguably limited in extent, we also review the empirical studies that exist on group treatment with attention to methodological approaches, measurement tools utilized, and key findings. For researchers and practitioners alike, this article provides a picture of the current state of the research literature on group treatment for survivors of torture, including the fact that there are very few, methodologically-rigorous studies at this time and even fewer that utilize an experimental design. In this way, the review also highlights opportunities that exist to strengthen the research in this area.

The genesis of this literature review comes from the work of the two U.S.-based national technical assistance providers: the National Capacity Building Project at the Center for Victims of Torture – working with all torture survivor rehabilitation programs – and the National Partnership for Community Training of Gulf Coast Jewish Family and Community Services – working with refugee-service organizations on mental health access.

This review is organized into seven main sections. Initially, we provide an overview of

the articles, the methodology used for the review, and then summarize the overarching rationale that authors described for using group based treatment. The review then looks at the primary group models utilized as well as key characteristics and considerations for group treatment. Lastly, we highlight the challenges associated with group treatment, review measurement approaches and conclusions, and then make recommendations for practice and research with respect to group treatment.

Methods and overview of the literature

For this literature review, the authors used the search terms "refugee and group treatment", "refugee and group work", "refugee and group therapy", "torture and group treatment", "torture and group work", and "torture and group therapy" with various search engines, including PsychInfo, PsychNet, and PubMed databases. The search was limited to articles published in English in online peer-reviewed journals, published dissertations, and book chapters that focused on group therapy with survivors of torture and severe violence. The authors selected 36 articles and chapters to review on the following basis.

The original intention was to include articles specific to survivors of torture as defined in Article 1 of the United Nations Convention Against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment.[41] However, the review process revealed that the body of literature on this topic is small at this time. While the majority of articles included are specific to torture survivors, due to the nascent state of literature on survivors of torture, the authors also decided to include select studies with highly traumatized survivors who had experienced mass political violence or politically-motivated sexual violence.

While it is acknowledged that there was strength in attending to group treatment issues unique to torture survivors, as there was substantial overlap in terms of treatment considerations, there are benefits to presenting a fuller picture of group treatment approaches. Articles pertaining to group therapy with child and adolescent survivors of torture were omitted, given that group therapy with children raises nuanced treatment considerations worthy of a separate analysis. Articles were also omitted on the basis that they were general to the trauma field, did not address group therapy directly, or did not sufficiently focus on torture survivors.

Why group treatment for torture survivors?

According to the literature, group treatment has a number of benefits for torture survivors. Firstly, groups addressed vulnerabilities in interpersonal and social functioning.[5, 13, 17, 19, 21] Torture and exile disrupts the most basic roles in survivors' lives and the meaning systems attached to those roles. Survivors grieved the loss of their role in their family and community.[5, 13, 17, 19, 21] Studies described groups as a format where survivors can come together to develop new relationships, reduce social isolation and reclaim a sense of trust and social connection lost through the torture experience.[6, 16, 17, 19, 21-23] For example, Hawthorne Smith and Edna Impalli,[16] psychologists at the New York University/ Bellevue Program for Survivors of Torture (PSOT), wrote that through participation in the support group, "It was hoped that clients would come to find that they were not alone"(p.338-339)[13] and the experience of "building relationships and feeling useful in helping others"(p.339)[13] would result in improvements of overall psychological symptoms and functioning.

Secondly, studies described groups as being more compatible for survivors coming from home cultures where there is importance placed on the role of the extended family,[16, 24] and identification with community and collectivist notions of self.[5, 13, 14, 19, 22] For example, a study by Kira et al.[19] described a supportive group for Somali women in which participants chose the name Bashaal for their group, a Somali word referring to a traditional gathering of women where they share triumphs and troubles. Similarly, a survivor likened the experience of being in a group for Sub-Saharan African men living in New York City to being under the Bantaba, a central tree in African villages where men gather to have important discussions.[5] These examples illustrate how gathering as a group to share life experiences can be a culturally-familiar and culturally-appropriate setting for diverse survivor communities. And yet, group based treatment may not be indicated for all cultural groups. For example, Kinzie et al.[7] described the difficulties of group therapy with Asians, particularly with Southeast Asians, where the formality of the culture may cause discomfort when speaking about the self.

Lastly, authors indicated that they used group-based treatment because it allowed providers to meet greater demand, despite limited funding and resources.[4, 7, 13, 14, 17, 20] This appeared most relevant in low- and middle-income countries and in humanitarian settings, where mental health services were nascent or altogether absent, but it is also discussed in a few of the U.S.-based studies. Working in Guinean refugee camps, Hubbard and Pearson[14] described a small group therapy model as the best treatment approach, due to the lack of dedicated mental health resources and vast exposure to violence and trauma among Sierra Leonean refugees. Similarly, Stepakoff et al.[17] ex-

plained how training refugee paraprofessionals to facilitate groups enabled 4,000 clients to participate in counseling and 15,000 refugees to be given other supportive services while living in refugee camps. Furthermore, the literature suggests that group therapy has demonstrated positive outcomes with lower costs. Describing group therapy services for Southeast Asian refugees in the U.S, Kinzie et al.[7] noted that, "A final reason for starting group therapy was the increasingly large case load which necessitated developing more efficient ways of treating patients"(p.159). Given experiences of large scale violence that have resulted in the massive displacement of populations around the world, the issue of meeting significant need with limited resources is a pertinent and practical consideration for torture survivor rehabilitation programs.

Types of group treatment
The authors were interested in analyzing the literature according to cross-cutting themes and approaches. Through our analysis, three primary group types emerged: supportive group therapy, stage one interventions and stage two interventions.[1] Using Herman's[1] language, stage one groups included techniques and skills that are comparable to what is done in the beginning of phase-oriented treatment for trauma with significant focus on the goals of safety and stabilization. Groups that were categorized as stage two included many of the same strategies as stage one groups but also included exploration of trauma memories. Supportive therapy groups refer to open group models which tended to primarily focus on creating a space for safe socialization, breaking isolation and developing relationships.
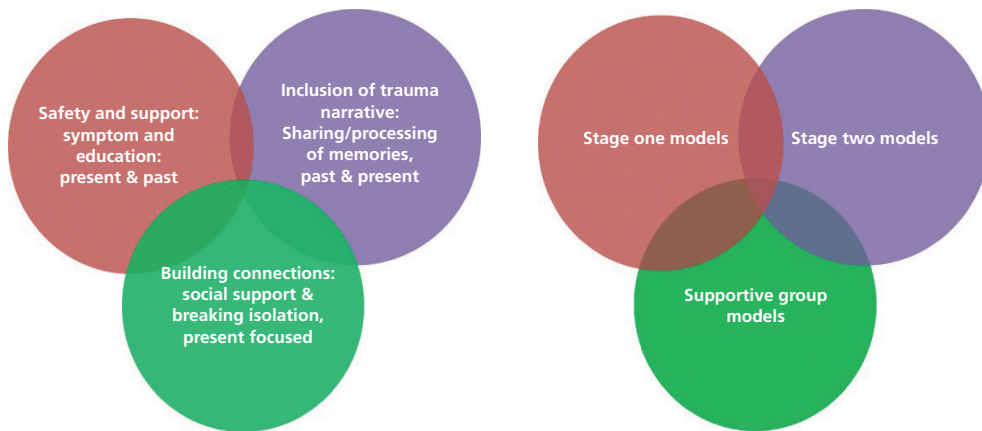
Looking at the literature by group type, as in the first part of this paper, offers an overarching framework for considering the

diverse set of articles using a phase-based language that is familiar in the torture survivor rehabilitation field. Moreover, it draws attention to the differences in groups in terms of the extent to which they include exposure elements, which is of course a seminal, and often disputed, issue in the field. In the second part of the paper, we examine particular characteristics of group treatment models such as group facilitation and open and closed groups, and look at the ways these treatment issues are approached in different contexts and with different survivor communities. Presenting the literature in this way allows for an overall framework while also not losing depth and detail associated with particular group treatment issues.

As with any categorization, there are limits to relying on three primary groups to summarize a diverse body of literature. While we found that most studies fit well into this formulation, some of the group models reviewed were less clearly demarcated and overlapped in terms of treatment goals and therapeutic activities (see Figure 1 below). These groups included a focus on present and past, and trauma-related concerns and

were implemented with greater flexibility in order to respond to the complicated and changing needs of survivors. For example, the stage two group described by Fishman and Ross[13] was focused on processing traumatic memories but also emphasized stability, anxiety and stress management, relaxation, and trauma education. As described earlier, we chose the term "supportive therapy group" to refer to an open-ended group that focused on building connections and discussing struggles in daily life, such as the one for African men at the PSOT.[5] In this way, supportive therapy groups resemble a number of the key characteristics of stage three groups as described by Herman.[1] However, supportive therapy groups for torture survivors differed in that they were often part of an initial treatment approach, as opposed to being offered after the processing of trauma memory, and were also offered throughout the course of treatment. These differences do not limit the relevance of the framework but rather function as a finding of the review, and generate insights about the ways that group treatment approaches used for torture survivors converge and differ from phase-

Figure 1: *Group models*

based approaches used more generally in the trauma field.

There were two group models that were distinct from the three primary group types. These were the Den-Bosch model,[12, 18, 32-34] a five-phase program model and the Free to Grow (FTG) intervention[35] used in Namibia. These approaches are described separately in subsequent sections. The table in the appendix summarizes key characteristics of the groups including group type, participant population, facilitator, and location and is organized alphabetically by author.

Supportive group therapy

Supportive group therapy refers to flexible, open-ended groups with a primary focus on present-day concerns. Many of these articles were presented in clinical case study format and describe single group cycles, guiding clinical principles, implementation processes and adaptations to group structure necessary for torture survivors.[5-7, 9, 10, 15, 16, 19, 21-24, 25-28] In general, these groups were utilized with resettled torture survivors and therefore emphasized concerns such as immigration, resettlement, housing, employment, trauma education, life skills, and opportunities to connect and socialize. Indeed, in addition to the direct burden of the torture experience, the burden of migration, acculturation, loss of family, change in social structure, work, possessions, and future are also at play for this population and are addressed in supportive groups.

Supportive groups for torture survivors often had flexible start and end times to accommodate transportation difficulties and unpredictable work schedules.[5, 22] Given their focus on building connections between survivors and in reducing isolation, these groups are well-suited to the needs of torture survivors at multiple points along the resettlement continuum and can work

well in tandem with other treatment modalities.

The wraparound approach,[19] modified specifically to address the cumulative traumas survivors of torture and severe violence face, is an example of supportive group treatment. This group incorporated community treatment teams who directly treated survivors and their family members and emphasized the importance of social support in the healing process. The wraparound approach provided "rehabilitation in the community by reconstructing a network of support and services in the natural environment"(p.63).[19] This flexible community-based model is adaptable to various communities and cultures, while emphasizing privacy, confidentiality, and normalization.

Stage one groups

Stage one groups are focused on safety and stabilization,[1] including anxiety and stress management, building emotion regulation skills, and trauma education and were generally time-limited and structured, meaning that facilitators followed a pre-set session guide or had specific treatment goals that were addressed over the course of the group. All of these studies were conducted in refugee camps or with torture survivors still living in their country of origin.[4, 9, 14, 17, 26, 29, 30] For example, the stage one model developed by the Center for Victims of Torture's healing initiative in Guinea[14] incorporated anxiety and stress management techniques, emotion regulation skills and trauma education. The facilitators in the Stepakoff et al.[17] study were the exception among those reviewed, in that facilitators were given considerable flexibility in structuring their group. Unlike a traditional stage one group, this model also blended Western and indigenous elements and was a component

of a larger program aimed at healing community-wide wounds.

There were several examples of stage one groups, such as the Tree of Life (TOL) model.[4, 20] This intervention, developed for use in Mashonaland, Zimbabwe, aimed to enhance participants' sense of wellbeing and safety in conditions of continuous violence and torture. This model conceptualized losses of social connection as a primary product of torture and violence and hypothesized that a stronger sense of interpersonal connection and "social capital" would buffer the psycho-social effects of violence. This group, held in workshop form over three days, was comprised of eight conversations led in circles.[4] During these conversations, participants reflected on the impact of history and violence on current life. While participants were able to share aspects of traumatic experiences, it is categorized as a stage one intervention because the primary focus is on connecting with others and reflecting on the way that current experiences shape wellbeing and community health. Mpande et al.,[4] compared TOL to the Psychoeducational and Coping Skills Workshop (PACS), which was similarly structured and based on the understanding that trauma education, coupled with coping skills, led to normalization and improved functioning. Also focused on stage one goals of symptom reduction, the study on the Hemi-Sync® (Hemispheric Synchronization) model[31] targeted sleep disorders and incorporated psychoeducation on sleep hygiene, body therapy exercises, a sleep journal, conflict-free imagery, and a Hemi-Sync® binaural beat CD[31] to minimize both sleep disturbances and high levels of nervous system activity, and to improve sleep quality.

The Cambodian Health Promotion Program (CHPP)[36] is a brief, small group intervention designed by staff at the Harvard Program in Refugee Trauma. The group is based on the premise that physical and mental health are intricately linked, and the intervention combined didactic information on health and wellness with small group exercises and the opportunity to share and discuss participants' experiences. This intervention is co-facilitated by an American mental health practitioner and a Cambodian community health worker, and focuses primarily on stabilization and building skills to address trauma-related, health issues.

Stage two groups

Interventions described as stage two groups shared an explicit focus on processing past trauma memories. These groups met for a much longer period of time than stage one groups, and typically lasted between six months and one year. Fishman and Ross,[13] for example, summarized a stage two group therapy with exiled Central and South American torture survivors that initially focused on developing group trust and cohesion and then sharing memories and trauma narrative. Most of the stage two groups used a closed group structure, where no new members could join after the start of the group – consistent with general trauma-informed principles. Due to issues of ongoing attrition, a study for refugee men from the Balkan wars[6] allowed new members to join as old members dropped out, and the authors described challenges associated with changing group composition. Some of the studies approached group work with an analytic and psychodynamic lens. Therefore, the articles focused greater attention on interpreting client statements and actions, as well as interpreting the interactions between clients and therapists.[6, 9, 13, 21]

Group-based program models

While most of the studies described a particular group intervention that took place

within a broader treatment program, some articles reviewed outcomes of program models that include several distinct group interventions. The Den-Bosch model[18, 32-34] is an eclectic, culturally syntonic, five-phase program model that incorporates "psychodynamic, cognitive-behavioral therapy (CBT), and supportive group treatment"(p.250) with nonverbal "psychomotor body therapy, art therapy, and music therapy"(p.118), with the goals of "understanding and incorporating trauma experiences and their consequences into identity . . . reducing intrusive PTSD symptoms, and . . . establishing corrective emotional experiences and repairing damaged core beliefs"(p.251).[18] This model is closed and time-limited to one year and includes two 90-minute group therapy sessions and three 75-minute nonverbal therapy sessions per week.[32] While this model was originally designed for resettled refugees and asylum seekers living in the Netherlands, the authors encouraged its use more broadly with individuals and groups.[18]

Free to Grow (FTG)
The Free to Grow (FTG) intervention[35] used in Namibia aimed to promote wellbeing among torture survivors who were not engaged in more typical clinical interventions. The FTG model[35] is a life skills empowerment program, designed in South Africa for survivors who are reluctant to engage in other therapeutic interventions. FTG promoted client engagement in the treatment process, while simultaneously increasing a participant's sense of empowerment – personally, in relationships, and with the broader community.

Characteristics of group models and considerations for group treatment
Homogeneous vs. heterogeneous groups
Studies differed in terms of the extent to

which participants in a group were similar to or different from each other in terms of gender, types and degree of trauma, faith and political affiliation, ethnicity, and country of origin. Authors expressed differing viewpoints about which format is optimal for group functioning. Some groups were homogenous, such as the group for Cambodian women described by Nicholson & Kay,[15] or the health promotion group for Cambodian adults described by Berkson at al.[36] However, other studies described groups with heterogeneous membership, such as the one at PSOT for Sub-Saharan African men.[5] Kinzie et al.[7] mentioned that "a group composed of members of the same ethnic origin rapidly regresses to the values and roles of the previous culture" (p.161),[7] and that this became an issue when men participated far more than women. Kira et al.[25] also noted that while homogenous groups tend to be preferred, "multi-ethnic groups help create tolerance and adjustment to the American multi-cultural society"(p.75).[25]

Smith and Impalli[16] were initially concerned that the varying politics and religions in their group would prevent cohesion, but found that heterogeneity became a source of strength and lead to discussions about traditional gender roles and whether and when it is appropriate for African men to cry. However, Drožđek and Wilson[18] advocated for homogeneity on certain planes: "It is helpful if members are homogeneous in terms of ego functioning, interpersonal skills, and ability to confront defenses. Members should be of the same gender and speak the same language" (p.252).[18] While they acknowledged the success of mixed gender groups for certain refugees, they discouraged it for victims of sexual violence. Von Wallenberg Pachaly[11] agreed and also stated that "homogenous

groups may be of greater help for victims of ethnic cleansing than for victims of individual torture" (p.275).[11] He continued to state his preference for working with heterogeneous groups, "because they correspond to the reality of life, are much richer in their mutual therapeutic possibilities, and also offer less disturbed patients a chance to come into contact with deeper layers of their personality structure"(p.275).[11] Von Wallenberg Pachaly[11] highlighted the need for pairing severely traumatized patients with at least one other such person in the group, to decrease group attrition. Traditionally, clients with a history of mental health crises or current suicidality would not be allowed to join a group because of concerns that they would not be stable enough to tolerate group participation. However, given the extreme nature of torture and very limited treatment services available, Hubbard and Pearson[14] and Fishman and Ross[13] argued for including participants with active or past suicidality.

Tocilj-Simunkovic & Arcel[27], on the other hand, began with homogeneous groups "because the reaction to trauma varied in men and women"(p.145),[27] but later found that mixed-gender groups provided more effective treatment. Smith[24] found that at times potential conflict due to political heterogeneity actually resulted in stronger group identification as "family". The facilitators had previously thought of the group as such, but felt it was important for the group to take this culturally-meaningful term for themselves. As von Wallenberg Pachaly[11] noted, "The primary task of the group is to take each victim back into the human family" (p.280).[11] Many torture survivors complain about social isolation foremost, and the group can provide a sense of social and familial connection.

While groups may have tremendous

therapeutic potential, there are a number of important group features that have to be carefully considered when planning for an intervention. Survivors may be hesitant to disclose experiences, distrustful of people from their country of origin, or of relationships more generally, and can vary tremendously in terms of their most pressing needs. All of these factors have to be weighed carefully when making decisions about how to structure groups and who to include in a particular group.

Closed vs. Open Groups
As described earlier, several researchers chose to conduct closed groups, most often in groups that intended to address trauma memories.[6, 9, 10, 13, 21, 37] Consistent group participation is considered important for developing trust and safety among group members[1] and this can be particularly critical in groups that intend to share and process highly stimulating trauma memories. Tocilj-Simunkovic & Arcel[27] allowed new members to join as old members dropped out, though the group experienced difficulty in accepting new members continuously, since the original members of the group had worked to establish a strong cohesion that was slowly built. Some of the group interventions promoted contact between clients outside of sessions in order to encourage social connection and reduce isolation.[5, 14, 16]

Decisions related to utilizing an open or closed group structure, and the extent to which members are in contact with each other outside of group sessions, are naturally related to overarching treatment goals. Whereas supportive group or stage one group models may be implemented with more flexibility in terms of ongoing membership and outside contact with group members, groups that intend to process trauma

memories need to be more cautious about changing the group composition over time.

Group Facilitation

One of the keys to effective group treatment is selecting facilitators who can manage the varied tasks and work well with the client population. The studies reviewed used group facilitators who were diverse in terms of gender, age, ethnicity, nationality, and religious affiliation. A number of studies emphasized or simply described using facilitators with high levels of clinical or trauma-related training and experience.[5, 6, 13, 15, 21] Fishman and Ross,[13] licensed therapists with experience treating trauma and torture survivors, observed improved relationships and reductions in trauma symptoms as a result of their stage-two group for exiled Chileans. In contrast, another study with Palestinian ex-political prisoners[9] compared the effectiveness of individual and group modalities and found individual treatment to be more beneficial. In this study,[9] the clinicians providing individual therapy were described as more highly educated and trained than those facilitating the group interventions. The study reported that the individual therapists were Master-level social workers or psychologists and trained in trauma treatment at the Copenhagen-based Rehabilitation Centre for Torture Victims, while the facilitators of the group therapy sessions were Bachelor-level graduates in psychology and social work. The outcome of the study shows that PTSD symptoms decreased with individual therapy but not group therapy. These findings raise questions about the relationship between clinical skill level and positive mental health outcomes, an issue raised by Mpande et al.,[4] though not addressed in outcome studies.

Other studies emphasized the importance of selecting facilitators who could be most

effective with the particular cultural group.[5, 13, 23] One case study[15] which focused on a support group for Cambodian refugee women described selecting an older American clinician to co-facilitate in order to reflect the Cambodian practice of seeking guidance and counsel from community elders. A study describing a group for Bhutanese families[19] utilized a bilingual clinician and Bhutanese community leader. The combined expertise of the facilitators was described as more beneficial given that participants were negotiating mental health, resettlement, and acculturation difficulties.[19] The co-facilitation model adopted for the Cambodian Health Promotion Program[36] was used to allow for reflection and integration of both Khmer health and Western medical concepts.

The issue of training local paraprofessionals as facilitators emerged as an important consideration for group-based interventions in refugee camps or other low-resourced or humanitarian settings. The group described by the Stepakoff et al.[17] study in Guinea, for example, was supervised by professional expatriates who recruited and trained refugee paraprofessionals to meet the needs of thousands of traumatized refugees living in the camps in Guinea. Hubbard and Pearson[14] used trained refugee peer counselors who became long-term program employees to decrease program attrition in their Guinea-based intervention. Bass et al.[38] trained staff at an international non-governmental organization to deliver group-based cognitive processing therapy to survivors of sexual violence in the Democratic Republic of the Congo.

There were a number of challenges, however, associated with facilitating groups for torture survivors. Kinzie et al.[7] discussed challenges negotiating gender dynamics between facilitators and participants.

Akinsulure-Smith,[5] Cvetković et al.[6] and Tucker and Price[21] described how facilitators and survivors discussed differences between norms in the survivors' countries of origin and in the U.S. In these studies, female clinicians facilitated groups with male clients from cultures where it would be rare for men and women to come together to share personal matters. Akinsulure-Smith[5] explained that, over time, male participants began to refer to the female facilitator as "Mama Africa", a term that captured their affection for her as well as their ability to integrate her as a woman into their group process. Several studies[5, 6, 13, 21] utilized a co-facilitator model as a way to manage the intense emotional experience of hearing accounts of torture and trauma in a group context.

Subtle dynamics can occur in group treatment, and Drožđek and Wilson[18] warned against the idealization of therapists as rescuers, and of the pitfall of trying to create an egalitarian relationship. They suggested that the facilitator remain the leader, but also curtail the group's expectations as to their potential: "It is important for the therapist to limit unrealistic expectations and unambiguously define the professional role"(p.258).[18] Von Wallenberg Pachaly[11] agreed and warned that therapists and facilitators may at times take on the "persecutor" role in re-traumatizing the patient, "because in certain regressed ego states a question, a gesture, or a therapist's mere presence may represent torture to a victim" (p.273).[11] It is crucial to a group's success to carefully consider the pairing of facilitators with certain participant types.

Group content
The studies varied in terms of their approach to group content. In a supportive group therapy model, Smith[24] advocated for an

experience where participants may share their trauma stories, but are not obliged to; there is no predetermined content area. As described earlier, Smith[24] stated that difficulties in daily life and concerns with family and resettlement were common group topics and that "outside client contacts are allowed and even encouraged"(p.310)[24] as a way to strengthen relationships developed in the group and reduce isolation. Tucker[10] describes a different perspective on group content. In that stage two intervention, any discussion beyond the realm of the focused trauma therapy was considered an "intrusion". She allocated the first 30 minutes of the group session to address logistical or daily concerns, such as where to locate food pantries. In this way, Tucker kept "the safe boundary around the reflective space of the group"(p.76)[10] intact in what she terms the "representational therapeutic space"[10] where group participants focus on intentionally processing their trauma. These two viewpoints are seemingly at odds but make sense when considering the vastly different purposes of the two groups.

Describing the Den Bosch model, Drožđek and Wilson[18] encouraged nonverbal techniques, such as massage or allowing participants to sit by leaning against one another, as well as dramatic techniques to strengthen group cohesion and address trauma symptoms. Similarly, Hubbard and Pearson[14] used role plays and traditional rituals for this purpose. Moreover, Stepakoff et al.[17] described how paraprofessionals facilitated social activities with clients and those not in therapy in the refugee camps, through activities such as art-making, games, team sports, music, storytelling, and sandbox play. These techniques were used to identify future clients and encouraged social interaction, fostered resilience and built upon the work that occurred in treatment.

Cultural syntonicity

The articles on supportive group therapy described the importance of including aspects of participants' home culture in the group format, though this is important for all groups involving diverse torture survivors. Some of the articles described sharing of food or using song or a cultural ritual to start or end group sessions.[5, 15, 22] Akinsulure-Smith et al.[22] describe how in one group for African women, participants started by exchanging purchased food but then evolved to preparing food for one another. Stepakoff et al.[17] emphasized the necessity of being as culturally syntonic as possible. Incorporating African approaches is evident by the mud brick counseling huts, which are circular with thatched roofs and "designed to provide a sense of safety, comfort, and familiarity for the clients"(p.926).[17] In addition, chants, clapping, drumming, healing rituals, songs, stories, and symbols are incorporated into group sessions. Berkson et al.[36] noted that the inclusion of rituals and cultural practices have importance well beyond their cultural familiarity and can signal a reclamation of cultural pride and heritage, which can be especially important for participants who have experienced ethnic cleansing or genocide.

Exposure

Studies varied in terms of the amount of exposure – or direct discussion and process-ing of traumatic memories –that is optimal for group treatment. Using the Den Bosch model, the authors found that exposure aids survivors in decreasing their isolation by shar-ing the commonality of the torture experi-ence and heightening group bonding. Drožđek and Wilson's 2004 study[18] compared three types of groups: a psychoeducation group, another group combining psychoedu-cation and supportive counseling, and the final one engaged in Narrative Exposure Therapy (NET). They found that "only in the narrative exposure therapy group did the majority of participants exhibit an absence of PTSD one year after treatment" (p.538).[18] The authors posit that the low drop-out rate in the NET group may be due to the small number of sessions per week (four, compared to more than double that amount usually required in the treatment model).

And yet, moving too swiftly into trauma memory work can be re-traumatizing for survivors and result in an escalation of symptoms.[1] Drožđek & Bolwerk[32] noted that while some therapists consider direct exposure more effective than vicarious exposure, others "advise against using exposure in group settings due to the risk of 'secondary traumatization' of the clients"(p.124).[32] The study from Bass et al.[38] used a randomized control trial design to test the efficacy of the cognitive-only model of Cognitive Processing Therapy (CPT), omitting the development of a trauma narrative, for survivors of sexual violence in the Democratic Republic of the Congo. The authors compared CPT to individual therapy and found the efficacy without exposure simi-lar to the full version of the therapy. Moreo-ver, this version was more suitable for the low-resourced setting in which they were working. Taken together, these studies suggest that decisions related to exposure can be informed by research findings, are client- and context-specific, and should be approached with care and consideration.

Challenges of group treatment

Because torture can undermine the capacity to connect with others, it may be difficult to convince certain survivors to join a group,[11] and several studies described barriers that survivors experience engaging in group treatment.[6, 13, 15, 21] As Smith[24] noted, "It is

also important to remember that many survivors have been tortured in conjunction with being interrogated for information by powerful others,"(p.300)[24] and that, consequently, survivors may not feel comfortable joining a group where they will be asked to share their experiences, for fear of not being believed or because they are unable to overcome their shame. Hubbard and Pearson[14] described "a reluctance to participate in groups due to issues of confidentiality . . . extreme anxiety about sharing histories of abuse with other group members"(p.15)[14] and severe withdrawal symptoms. Tocilj-Simunkovic & Arcel[27] further suggested that "due to the impossibility of accepting what is being said by one member, e.g., about torture experiences, the other group members deny the topic . . . by resisting participation and reacting with silence and passivity"(p.144).[27]

Curling[35] described the "Free to Grow" (FTG) empowerment workshop, aimed at survivors of torture "who had shown great reluctance to enter into psychotherapeutic interventions"(p.9).[35] The article describes the FTG model, and though Curling's sample size is too small to infer significance, 90% of participants reported improved communication, listening, social-interactive skills, self-knowledge, and assertiveness. Five months after program completion, 75% of participants reported improved empowerment scores, pointing to FTG as a potential model for sustained improvement and a workshop to consider for those reticent to enter group therapy.[35] However, the studies found that groups can restore community for those who are ready to join them. As Tucker[10] noted, "isolation is caused by the politically motivated assault on each person's ability to trust others through torture and rape; it is compounded by the shame that goes with the survival of these kinds of

brutalities"(p.72).[10] For those who have overcome their aversion to the idea of group therapy, "an increased sense of community and belonging does foster individual healing in survivors" (p.305).[24] Given the pervasive distrust of others that is common for torture survivors,[6, 13] most studies emphasized allowing time for participants to develop a sense of trust and more time to complete a group cycle than may be indicated in more typical group models. Kinzie et al.[7] described using 10 months of socialization experience before beginning formal group work. Indeed, giving significant consideration to the timing of group interventions, both how long groups should last and when participants are most likely to be receptive, are central to their success.

Measuring the efficacy of group treatment

Supportive group models

The articles on supportive therapy group described a number of benefits associated with group treatment and the particular outcomes that were highlighted varied according to group type and treatment context. Supportive group therapy with resettled torture survivors described improvements in functioning and wellbeing, an increased sense of social support, and reductions in trauma symptoms. On the effects of a support group for Cambodian women, Nicolson and Kay[15] concluded that, "in addition to increased comfort talking about their problems, the women established a social support network"(p.475).[15] Smith's[24] African group did not measure symptom reduction quantitatively, but measured progress qualitatively through increased group engagement and increased adaptive capability. While these articles convey the value of supportive group therapy models in reducing the social vulnerabilities of torture and exile,

there is a need for a broader evidence base moving forward. The findings are mostly based on clinical observations or limited qualitative reports from participants, involve small numbers of participants, and are based on one cycle of group implementation. Additional outcome-based studies, informed by clinical insights, are needed to build empirical support for these group models.

Stage one interventions
The studies on stage one interventions occurring in refugee camps and conflict settings reported a range of benefits, including increased social capabilities, improved family communication, better stress management skills, and an overall reduction in trauma-related symptoms. The randomized control trial by Bass et al.[38] assessed changes in symptoms pre- and post-treatment using the Hopkins Symptom Checklist (HSCL) and PTSD Checklist. The authors controlled for a number of variables in regression analyses (i.e. village-level differences, differences in designated facilitator, experiences of violence during the intervention) and, despite taking a very conservative approach to analyzing findings, still found that Cognitive Processing Therapy (CPT) had a significantly superior effect on trauma-related symptoms as compared to individual support. Hubbard and Pearson[14] also measured trauma-related symptoms using the HSCL and assessed social support in a semi-structured interview by asking participants, "How many people can you go to for help?" They reported significant changes in trauma-related symptoms and increases in perceived social connection.

The studies from Zimbabwe[4] and the DRC[38] stand out in that they used an experimental design to measure treatment outcomes, thereby reducing issues of selection bias and increasing confidence in the findings. Moreover, the international studies contribute to the topic of group treatment by utilizing evaluation approaches that combine culturally-specific measures and adapted Western measures.[4, 14] The Mpande et al. study,[4] for example, developed the Zimbabwe Community Life Questionnaire in order to evaluate changes in survivors' sense of engagement with other members of the community, concern for others, and positive attitudes toward community healing post-intervention. The 40-item measure assesses participants' overall sense of community and community engagement and was developed through extensive ethnographic interviewing and measurement development techniques.

A number of the authors identified a dearth of valid cross-cultural and culture-specific measures as a primary challenge of evaluation. Most studies used measures of PTSD, depression, and anxiety with tools such as the Harvard Trauma Questionnaire (HTQ), HSCL and the PTSD Checklist without evaluating reliability and validity for the particular study population. While this is a demanding research task, it is a necessary one in order to build confidence in the measures being used. As Droždek and Bolwerk[32] note, "When using the instruments, one has to be cautious about cross-cultural use of the scale cutoff points determined in one cultural group to another"(p.125).[32] Further reading of the studies from Zimbabwe,[4] Guinea,[14] and the Democratic Republic of the Congo[38] is recommended for those interested in culture-specific measurement development, as both competently describe the process that is required and resources needed.

Stage two groups
Some of the studies on stage two groups used clinical observation in lieu of quantitative

evaluation methods to draw conclusions about changes pre- and post-group. For example, a study by Tucker and Price[21] using a psychodynamic group therapy process with Kosovar torture survivors concluded that "the groups provided a symbolic home for members" (p.277).[21] Working with exiled survivors from Latin America, Fishman and Ross[13] concluded that group connections are the mechanism that promotes positive changes in individuals. In fact, the group "fosters individual healing by generating a sense of community and membership" (p.141).[13]

Drožđek et al.[34] used the HTQ and HSCL to evaluate changes in core PTSD symptoms. The authors found that, "Reductions of PTSD, anxiety, and depression symptoms was maintained up to 5 years (60 months) post treatment . . . After 5 years, all symptoms started to worsen again"(p.384).[34] However, seven years post-treatment, symptoms were still lower than before the treatment began. As far as the authors of this literature review have found, this is the only longitudinal study of the effects of group treatment, and showcases the need for further research along these lines.

In addition, a 2013 study by Drožđek et al.[37] indicated that asylum seekers who obtained permanent refugee status during the course of treatment demonstrated the greatest benefit, and this was compared to participants who already had refugee status. The authors suggested that it is the change in immigration status that is significant and reasoned that the refugees in the group may have been experiencing some of the longer-term challenges of resettlement. The findings, however, highlight the interplay between treatment interventions and broader contextual realities and seem to suggest that in-depth group treatment can be successful for participants who are struggling with ongoing stress and instability.

Salo et al.'s[9] study with Palestinian ex-political prisoners also used the HTQ, Somatic Symptom Questionnaire, and Posttraumatic Growth Inventory to evaluate the benefits of individual therapy versus group therapy. The study reported greater reductions in trauma-related symptoms for those in the individual treatment cohort and very limited benefits for those participating in group therapy. However, the number of participants (39) and the number in the control group (80), coupled with the educational and training differences between the individual counselors (Master-level social workers and psychologists specialized in trauma treatment at Copenhagen's Rehabilitation Center for Torture Victims) and group facilitators (Bachelor-level social workers and psychology graduates) may explain this discrepancy.

In support of nonverbal techniques being included in group work, such as art therapy, Drožđek et al.[33] measured the efficacy of different types of groups on decreasing symptoms of anxiety, depression, and PTSD. Three types of groups were measured: one group including three Non-Verbal Therapy sessions (NTS) and two group Psychotherapy Sessions (PS) three days a week; one group with three NTS and two PS twice a week; and one group with two NTS and two PS twice a week. The results showed that the first two types of groups are equally effective, and more so than the third type, so that "the number of nonverbal treatment sessions applied in a week's time is a more important variable than the number of treatment days per week"(p.763).[33]

Additional measurement considerations
The need for more empirical studies was identified by a number of authors. The current state of the empirical literature is, indeed, a major finding of the literature

review. At this time, there are very few studies using methodologically rigorous quantitative or qualitative approaches. The authors emphasized the difficulties of engaging in meaningful outcomes studies without dedicated research staff.[5, 13, 19, 22] Some of the particular research challenges included illiteracy among survivor populations, which complicates the use of self-report measures, and survivors' cultural traditions and sense of gratitude toward service providers, which can inhibit the reporting of negative feedback. The studies also described difficulty obtaining follow-up evaluation data from vulnerable, impoverished, and itinerant survivors whose living conditions change frequently.[14, 22] Moreover, group based interventions were frequently offered as part of an overall treatment plan. And yet, these outcome based studies often did not clearly describe the other services that participants engaged in, nor did they control for them in their analyses. Therefore, the findings raise questions about the isolated effect of group therapy.

For torture survivor rehabilitation programs in the U.S., it is important to note that the studies that used or developed culturally-specific measures were working with one main cultural or linguistic group. The question is how to integrate culturally-specific or culturally-meaningful evaluation methods into U.S. torture rehabilitation settings where programs are serving survivors who originate from many countries of origin. Moving forward, program-researcher partnerships may be a way to address these and other core research questions and build a broader evidence base for group treatment.

Conclusions and implications
While group treatment approaches have been a central part of the work done in torture rehabilitation settings, this review shows that

the topic is not well documented in the literature. The studies reviewed endorsed group work in conjunction with other treatment services and found group work to be well-suited to the particular vulnerabilities of torture survivors in terms of addressing post-trauma symptoms, regaining a sense of community, minimizing isolation, and receiving and sharing support.

Yet, despite the conceptual rationale for group treatment, very few of the studies actually measured changes in social and interpersonal wellbeing as part of their evaluation methodology. Hubbard & Pearson[14] asked participants how many people they could go to for help[14] and in doing so, provided an important link between the conceptual rationale for group treatment and actual measurement. However, this question seems to provide information about participants' social networks more broadly. Questions still remain about relationships that may have developed in the group itself and shifts that may have occurred in sense of belonging, trust and fundamental connection to others – all aspects of social functioning suggested by the group treatment literature. Across the studies, the major outcome variables of interest are symptoms of posttraumatic stress, anxiety and depression. Moving forward, there is a need to integrate social and interpersonal variables more directly into research designs in order to build empirical evidence. This will help to answer questions about the theory of change proposed by studies on group treatment, including the extent to which survivors' perception of social support and connection does change as a function of group participation as well as how changes in these dimensions of wellbeing may moderate or buffer mental health symptoms.

The findings from the studies in the

DRC,[38] Guinea[14] and Zimbabwe[4] found improvements in symptoms and functioning in conditions of ongoing war and violence. However, "safety" in both a literal and figurative way is often considered a pre-condition for treatment. Determining when and how to intervene with torture survivors is a primary consideration in treatment settings. These studies offer some insights to this key question for survivors living in volatile settings and push our thinking about the potential for therapeutic change despite precarious life circumstances and even ongoing exposure to violence.

As has been stated throughout this review, more methodologically rigorous studies are needed in order to build the evidence base for group therapy for torture survivors, as well as studies including larger numbers of participants. Additional data-driven investigations on supportive group therapy can strengthen the work already being done by clinicians in the field. In this review, interventions are facilitated by licensed clinicians, paraprofessionals, and bicultural staff. Future research could examine group treatment outcomes according to group facilitators' level of training. Additional research could also center on questions related to group therapy models across cultural contexts. For example, studies could implement the same group therapy model with a number of different cultural groups to determine if there are differing results and benefits. This type of study could help guide practice decisions in torture rehabilitation settings. Taking into account the varied settings and geographical locations, programs in the U.S. could reproduce studies to measure the effectiveness of these models with exiled and resettled torture survivors in the U.S.

The articles examined in this review provide a picture of the current literature on group-based treatment and also highlight a number of areas for research and knowledge-building. While the practice literature highlights key group treatment characteristics and consideration, there is a need for quantitative and qualitative studies including, low-cost, feasible research designs that treatment centers can implement to gather outcomes and build confidence in different models. Moving forward, programs can integrate a minimum of one outcome measurement tool in group interventions to examine before and after group gains, comparing them to those on the waitlist. Measurement tools could also be administered at various points over the course of treatment to gather information on the amount of group treatment necessary to achieve positive outcomes. In short, there are numerous opportunities for practitioners and scholars alike to partner to conduct meaningful research with the ultimate goal of improving the understanding of the effectiveness of group treatment for torture survivors, and by doing so, improving the health and wellness of torture survivors.

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41. Article 1 of the United Nations Convention Against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (UNCAT): "... 'torture' means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions.

Appendix

Table: *Intervention characteristics[i]*

Author	Intervention	Participants	Facilitator	Treatment Location
Akinsulure-Smith (2012)[5]	Supportive group therapy	African males from 16 countries aged 20 to 60	Clinicians	Country of resettlement, U.S.
Akinsulure-Smithet al. (2009)[22]	Supportive group therapy	West African women (refugees and asylum seekers)	Clinicians	Country of resettlement, U.S.
Bass et al. (2013)[38]	Stage 1 (Cognitive processing therapy)	405 Congolese women	Paraprofessionals	Country of origin
Berkson et al. (2014)[36]	Stage 1 (Cambodian Health Promotion Program)	126 Cambodian male and female torture survivors	Clinician and bicultural staff	Country of resettlement, U.S.
Center for Victims of Torture Manual[39]	Stage 1 group	Range of diverse torture survivors, 7-13 per group	Clinicians	Country of resettlement, African refugee camps & U.S.
Curling (2005)[35]	Engagement group (Free to Grow self-empowerment workshop)	11 Namibian torture survivors	Not indicated	Country of origin, Namibia
Cvetković et al. (1995)[6]	Supportive group therapy	Male torture survivors from Balkan wars	Clinicians	Country of resettlement, Serbia
Drožđek & Bolwerk (2010a)[12]	Group-based program model (Den Bosch Model)	78 male and 10 female Iranian, Afghani, Iraqi and Caucasian torture and war trauma survivors	Clinicians	Country of resettlement, Netherlands
Drožđek & Bolwerk (2010b)[32]	Group based program model (Den Bosch model)	78 male and 10 female Iranian, Afghani, Iraqi and Caucasian torture and war trauma survivors	Clinicians	Country of resettlement, Netherlands

[i] Number of participants are listed if they were addressed in the article.

Author	Intervention	Participants	Facilitator	Treatment Location
Droždek et al. (1998)[40]	Group based program model (Den Bosch model)	28 mostly male, Bosnian, Muslim, and Croat concentration camp prisoners	Bi-cultural Clinicians	Country of resettlement, Netherlands
roždek et al. (2012)[33]	Group based program model (Den Bosch model)	65 Iranian and Afghani male torture survivors	Clinicians	Country of resettlement, Netherlands
Droždek et al. (2013)[37]	Group based program model (Den Bosch model)	47 Iranian and 19 Afghani male torture survivors	Clinicians	Country of resettlement, Netherlands
Droždek et al. (2014)[34]	Group based program model (Den Bosch model)	69 Iranian and Afghani males torture survivors	Clinicians	Country of resettlement, Netherlands
Fischman & Ross (1990)[13]	Stage 2 group	Six male and two female survivors of torture from Central and South America	Bi-cultural clinicians	Country of resettlement, U.S.
Fürstenwald (2005)[31]	Stage 1 group (Hemi-Sync® group treatment for sleep disorder)	One group of five Arab male torture survivors; one group of four Arab female and one Bosnian female torture survivor	Clinicians	Country of resettlement, Denmark
Hess (2008)[29]	Stage 1 group	Sierra Leonean refugees	Clinicians & paraprofessionals	Refugee camp, Guinea
Hubbard & Pearson (2004)[14]	Stage 1 group	Sierra Leonean refugees	Clinicians & paraprofessionals	Refugee camp, Guinea
Kinzie et al. (1988)[7]	Supportive group therapy	Vietnamese, Cambodian, Lao and Mien men and women (refugees)	Clinicians & bicultural staff	Country of resettlement, U.S.
Kira (2002)[8]	Supportive group therapy (Wraparound approach)	General description but model built on work with Iraqi torture survivors	Multidisciplinary team	County of resettlement, U.S.

Author	Intervention	Participants	Facilitator	Treatment Location
Kira et al. (2010)[25]	Supportive group therapy (Wrapa-round approach)	Somali, Ethiopian and other Sub-Saharan female war trauma and torture survivors and Bhutanese torture survivors	Clinicians and Bicultural paraprofessionals	Country of resettlement, U.S.
Kira et al. (2012)[19]	Supportive group therapy (Wrapa-round approach)	African and Somali women; Bhutanese families	Clinicians and Bicultural paraprofessionals	Country of resettlement, U.S.
Manneschmidt & Griese (2008)[26]	Supportive group therapy	109 Afghan women	Clinicians	Country of origin, Afghani-stan
Mpande et al. (2013)[4]	Stage 1 group (Tree of Life Trauma Healing workshop and Psycho-education and Coping Skills Workshop)	139 Zimbabwe torture survivors	Clinicians & paraprofessionals	Country of origin, Zimbabwe
Nicholson & Kay (1999)[15]	Supportive group therapy	15 Cambodian women	Clinicians & bicultural staff	Country of resettlement, U.S.
Reeler et al. (2009)[20]	Stage 1 group (Tree of Life empowerment workshop)	73 Zimbabwe torture survivors	Trained and supervised survivors	Country of origin, Zimba-bwe
Salo et al. (2008)[9]	Stage 2 group	39 Palestinian ex-political prisoners	Clinicians and BA level counselors	Country of origin, Palestine
Smith (2003)[24]	Supportive group therapy	French speaking African torture survivors and Tibetan torture survivors	Clinicians	Country of resettlement, U.S.
Smith & Akinsulure-Smith (2011)[23]	Supportive group therapy	African survivors of torture	Clinicians	Country of resettlement, U.S.
Smith & Impalli (2007)[16]	Supportive group therapy	French- and English-speaking African refugees, asylees and asylum seekers	Clinicians	Country of resettlement, U.S.

Author	Intervention	Participants	Facilitator	Treatment Location
Stepakoff (2007)[30]	Stage 1 group	Sierra Leonean and Liberian refugees	Clinicians & paraprofessionals	Refugee camp, Guinea
Stepakoff et al. (2006)[17]	Stage 1 group	Sierra Leonean and Liberian refugees	Clinicians & paraprofessionals	Refugee camp, Guinea
Tocilj-Simunko-vic& Arcel (1998)[27]	Stage 2 group	10 Bosnian Muslim refugees	Clinician	IRCT in Zagreb, Croatia
Tribe & Shackman (1989)[28]	Supportive group therapy	Colombian, Peruvian, Iranian, Eritrean, Bolivian, Angolan, Turkish, and Iraqi female torture survivors or victims of organized violence	Clinician	Country of resettlement, UK
Tucker (2011)[10]	Supportive group therapy	Afghanistan, Burundi, Cameroon, Congo, Eritrea, Ethiopia, Guinea, Iraq, Iran, Kosovo, Lebanon, Turkey	Clinicians	Country of resettlement, UK
Tucker & Price (2007)[21]	Supportive group therapy	Kosovan women and young adults	Clinicians	Country of resettlement, UK
von Wallenberg Pachaly (2000)[11]	General recommendations	East Germany and not specified	Clinicians	Country of Resettlement, Germany