

Psychological, social and welfare interventions for psychological health and well-being of torture survivors (Protocol)

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[Intervention Protocol]

Psychological, social and welfare interventions for psychological health and well-being of torture survivors

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ABSTRACT

This is the protocol for a review and there is no abstract. The objectives are as follows:

Primary objective

1. To assess beneficial and adverse effects of psychological, social and welfare interventions versus no treatment for the reduction of psychological distress in torture survivors.

Secondary objectives

2. To describe the quality and generalisability of the studies evaluating the effects of these treatment approaches on torture survivors, and specifically:

- to provide an objective assessment of risk of bias in these studies;
- to describe the specific populations evaluated in studies of torture survivors (including demographics, torture experiences and psychological status);
- to describe the variety of interventions that have been evaluated in these populations; and
- to describe the outcomes evaluated in these intervention studies.

BACKGROUND

Reports of torture and other ill-treatment come from over 150 countries (AI 2010). The International Rehabilitation Consortium for Torture Survivors (IRCT 2010) estimates around

400,000 torture survivors live in the European Union alone, with similar estimates in the USA (Jaranson, 1995).

Unlike many other client groups, the health concerns of torture survivors are addressed in the literature and in clinical practice,

not specifically or solely in terms of common health problems, but by their experience of torture and other ill-treatment as defined by the United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT) (UN 1984), Article 1.

Torture is a deliberate assault upon the body, the psyche, the identity and the integrity of the person, aiming to dehumanise, degrade, destroy or debilitate and render the individual helpless. Its impact on psychological health can be short term and/or long-lasting and may affect the individual's interpersonal relationships. The impact of torture can extend beyond the individual to his/her family, community and society by perpetuating uncertainty, mistrust, suspicion and terror. Individual problems in physical, psychological and social health can result from both physical and psychological methods of torture, usually used in combination. The physical, psychological and other dimensions of well-being interact and manifest in complex and diverse ways, impacting on the capacity of individuals to function in daily life within their families and communities. Additionally, torture survivors in countries of exile can experience many additional difficulties, impacting on their well-being (e.g. legal proceedings, racism, inadequate housing or homelessness).

Physical health problems related to torture have been widely documented (Jacobs 2001; Moreno 2002; Norredam 2005; for a review see Jaranson 2011; Montgomery 2011; Quiroga 2005), as have psychological health problems (e.g. Basoglu 2001; Johnson 2008; Patel 2007). Torture-related physical health problems not only cause disability or restricted functioning but can also produce additional psychological problems, resulting in significant impact on overall social functioning and well-being of torture survivors.

Description of the intervention

There is limited information about the types of interventions provided to torture survivors. The available literature (McIvor 1995; Quiroga 2005) points to a range of interventions, some psychological, some medical, and many involving a variety of approaches intended to address the difficulties experienced by torture survivors, including welfare issues, legal proceedings related to their asylum claims, housing and social integration. Since there is no evidence of a psychological syndrome specific to torture (Westermeyer 1998), the treatment literature inevitably focuses on the treatment of PTSD, as one diagnosis, amongst torture survivors.

1. Psychological interventions aim to change cognitive, emotional or behavioural outcomes and, in this population, can be delivered to the individual, family, group, or community. The intervention may draw on a variety of theoretical and therapeutic schools, but can be grouped into broad models including behavioural, cognitive behavioural, integrative, humanistic and psychodynamic psychological interventions.

2. Social interventions aim to increase social involvement or participation to improve survivors' health and well-being, and may be delivered at individual or group levels. The focus of the intervention may vary, from educational initiatives to redress.

3. Welfare interventions aim to benefit survivors' health and well-being through improving social conditions such as housing or access to health services, and are usually delivered at the level of the community.

How the intervention might work

Psychological interventions, with or without cultural adaptation, may target a specific problem such as flashbacks to the trauma, or a broad spectrum of mood disorders; interventions can effect change via a number of mechanisms, including exposure and/or emotional processing with/without cognitive restructuring, cognitive processing, meaning making, and/or interpretation. Psychological interventions may additionally draw on political (as in documentation) or educational principles.

Social interventions can effect change through reframing or reinterpreting the relationships of the survivor with their family or community. They may improve social functioning, social integration and participation, and restore trust. Social interventions may also draw on political (as in public recognition of wrong) and educational principles.

Welfare interventions aim to improve the material conditions (such as housing) and environmental and service context (such as healthcare and availability of purposeful activity) which are associated with mental and physical health and wellbeing.

Why it is important to do this review

In the era of evidence-based healthcare, there is considerable emphasis on services providing treatments demonstrated to be effective. However, evidence for interventions with torture survivors comes predominantly from studies which involve neither torture survivor populations, nor populations diverse in cultural, ethnic, religious and political backgrounds and whose first language is not English. Arguably, both healthcare provided to torture survivors, and the methods and tools used to evaluate its relevance, effectiveness and impact, are based on concepts of health and well-being, and psychological models and outcome tools, which are not developed or validated with torture survivors. A previous review found very few studies had been conducted, all with significant limitations, including lack of control groups, variable use of diagnostic criteria, lack of validation of the measures used, and very small sample sizes (Quiroga 2005).

Most of the literature on psychological and physical health difficulties experienced by torture survivors (before or without treatment) is based on professional or academic accounts, much in the form of clinical opinions and case studies (for reviews see Lund

2008; Quiroga 2005). There is relatively little literature on outcomes of healthcare interventions with torture survivors, and what exists is dominated by case studies and clinical narratives, with few cohort studies and fewer trials. Some of these studies have aimed to raise awareness (and funding) for specific initiatives as well as informing the wider field, so political expediency has often been more important than academic integrity. In the literature examining healthcare outcomes for torture survivors, there is widespread use of assessment or evaluation tools, which are frequently diagnosis-based and developed in the West for Western, English-speaking populations and standardised on the same populations. Few of the tools translated for the study of torture survivors have demonstrated validity (Bracken 1995; Johnson 2008; Patel 2003; Thakker 1999), and many traditional assessment and outcome measures have been criticised for failing to demonstrate linguistic or semantic equivalence, thereby lacking construct validity for culturally diverse populations (e.g. Elsass 2009; Gurr 2001; Hollifield 2002; Mahtani 2003; Newlands 2004; Patel 2000; Van Ommeren 2001) including many refugees and asylum seekers who are survivors of torture.

Whilst there exists a vast body of research on the treatment of PTSD in various populations, such studies are rarely based on torture survivor samples (Bisson 2009; Nicholl 2004). They are therefore unlikely to address the range of difficulties beyond PTSD and depression (e.g. racism, destitution) experienced by torture survivors (for example Patel 2007). There are numerous methodological problems with applying psychiatric diagnostic criteria to this client group (Quiroga 2005) and questions remain about the validity of psychiatric diagnoses in general (Boyle 1999; Boyle 2002; Kutchins 1997; Pilgrim 1999). In particular, the validity of a diagnosis of PTSD in torture survivors has been challenged as medicalising the sociopolitical problem of torture (Bracken 1995; Bracken 1998; Patel 2003; Summerfield 2001).

There are no systematic reviews on which treatment approaches are effective with torture survivors experiencing a range of psychological, social, welfare and interpersonal problems, hence the need for this systematic review. In view of the wide range of evidence that might be relevant to the treatment of this population, this review will be as inclusive as possible. Unless comparable studies are identified, the review will not attempt to directly compare the effects of different interventions, and instead will provide a detailed description of the available evidence, summarising the features of these studies and describing treatment outcomes for any specific diagnostic groups identified.

OBJECTIVES

Primary objective

1. To assess beneficial and adverse effects of psychological, social and welfare interventions versus no treatment for the reduction of psychological distress in torture survivors.

Secondary objectives

2. To describe the quality and generalisability of the studies evaluating the effects of these treatment approaches on torture survivors, and specifically:

- to provide an objective assessment of risk of bias in these studies;
- to describe the specific populations evaluated in studies of torture survivors (including demographics, torture experiences and psychological status);
- to describe the variety of interventions that have been evaluated in these populations; and
- to describe the outcomes evaluated in these intervention studies.

METHODS

Criteria for considering studies for this review

Types of studies

Randomised controlled trials (RCTs), cluster RCTs, and quasi randomised controlled trials (QRCTs) will be included. QRCTs will be included because, due to the difficulties of conducting RCTs in this population, a very small number of RCTs are expected to be identified.

There will be no restrictions on publication type, status, language or date. If full details can be obtained from the authors, conference abstracts will be included, as relevant material is often published by torture survivor centres themselves. Where there is an indication that there are data in conference publications and the contact with authors is unsuccessful, such studies will be indicated in a separate section labelled 'studies awaiting classification'.

Types of participants

Formal diagnoses in these populations are frequently not available. Therefore, the review will not be restricted to participants meeting specific diagnoses, but will instead include participants who have survived any type of torture, as defined by the study authors. Torture survivors may be found among refugees, asylum seekers, war survivors and survivors of organised violence, and in diverse settings, such as prison, detention centre, refugee camp, accommodation centre, healthcare facility, and community.

Participants of all ages will be included and, as far as possible, studies on children and young people (<18) and those targeting adults will be analysed separately. Exceptions include studies evaluating family or other systemic interventions. Where necessary, authors will be contacted to request separate data for children and adults.

Types of interventions

Interventions provided in this field tend to be pragmatic and rarely follow treatment manuals/protocols or meet the strict criteria expected in other settings. For this reason our inclusion criteria is broad. However, in [Appendix 1](#) we set out a full list of the psychotherapies, as defined by the Cochrane Collaboration Depression, Anxiety and Neurosis Group, so that readers may understand how these therapies relate to one another.

We will include any psychological, social or welfare intervention which aims to improve health and well-being of torture survivors.

1. Psychological interventions. These will include psychodynamic and psychoanalytic therapies, behavioural and cognitive psychotherapies (including CBT, exposure therapy), interpersonal psychotherapy, narrative therapy, cognitive analytic therapy, anxiety/stress management approaches, systemic psychotherapies, counselling, supportive and experiential psychotherapies, art therapy, drama therapy, dance therapy, eye movement desensitisation reprocessing (EMDR), hypnotherapy. These interventions may be undertaken with individuals or with families or groups.

2. Social interventions. These consist of involvement in community activities, reparation and judicial activities, educational initiatives (such as learning the host country language), and others.

3. Welfare interventions. These are exemplified by provision of information about legal and welfare rights and entitlements, finding nursery and school places for children, productive and creative activities including work initiatives, and others.

Intervention setting

Interventions can be delivered in any setting, including healthcare clinics and other healthcare facilities, refugee camps, communities, survivors' homes and detention facilities.

Comparators

The control comparison will be waiting list, no treatment, standard care/access to standard care, attention control.

We will include trials where the intervention is added to non-psychosocial standard care given to both groups.

Equivalence trials will be included, but only if the comparator arm can reasonably be treated as a 'treatment as usual'. For this reason, non-equivalence trials (comparison of two active treatment with the hypothesis that their effects do not differ) will be excluded.

Rehabilitation services for torture survivors have arisen largely from psychological interventions. Medical interventions, including pharmacological interventions, where offered, are usually offered in combination with other psychosocial interventions and will therefore be excluded from the review.

Types of outcome measures

One of the objectives of this review is to describe the outcomes evaluated in these studies. We will summarise any measures of psychological health benefit and well-being. However, studies of populations which include torture survivors address a very wide range of outcomes, including many non-standardised measures specifically developed for that study ([Jaranson 2011](#)). Rarely do measures undergo the conceptual scrutiny which should precede translation and testing ([Johnson 2006](#)) and measures are often not translated into the first or fluent language of research participants and tested before use (only a few trauma instruments have been translated and undergone some validity testing in some languages). Furthermore, it is not uncommon to use interpreters to assist in data collection (see [Vara in press](#) for more detail), compromising reliability (for example, by introducing variation in the use of terms and response options).

Where data are provided for specific outcome measures that can be summarised, both continuous or categorical data will be included.

Primary outcomes

1. Reduction on a scale of psychological distress, e.g. General Health Questionnaire (GHQ); Short Form Health Survey (SF-12) Mental Health subscale.

2. Any adverse event such as suicide or self-harm.

Secondary outcomes

1. Change (positive or negative) in psychological status or target behaviour. This is likely to be variously measured as change in psychological and emotional symptoms (such as depression, PTSD, anxiety), which will be pooled; as change in diagnostic category (such as depression or PTSD); or as individual or group level change in a target behaviour.

2. Change (positive or negative) in quality of life or well-being, for which there are multiple scales either assessing life quality or global satisfaction with life; extent of disability.

3. Increased participation and functioning, as measured by engagement in education, training, work, or community activity.

4. Change in quality and/or quantity of family or social relationships.

5. Ratings of psychological function made by others, including clinicians; and for children: parents, or teachers (ratings by parents or teachers of children's status are widely used in psychological interventions.)

6. Ratings of the intervention itself, such as satisfaction with intervention, or therapeutic alliance.

Search methods for identification of studies

Searches will be conducted on electronic databases, websites and the handsearching of reviews and reference lists.

Electronic searches

Bibliographic databases and trial registers:

- PsycINFO (Online database of psychological literature)
- MEDLINE (Online database of health and medical journals and other news sources)
- EMBASE (Online database of health and medical journals)
- Web of Science (Online multidisciplinary database covering all sciences)
- CINAHL (Online database of nursing and allied health literature)
- The Cochrane Central Register of Controlled Trials (CENTRAL)
- Lilacs (Online database on health sciences, published in Latin America and the Caribbean)
- OPENSIGLE (Online database of reports and other grey literature produced in Europe until 2005).
- [WHO: International Clinical Trials Registry Platform \(ICTRP\)](#)
- PILOTS (Online database, Published International Literature On Traumatic Stress)

Searching other resources

- Online Library of the [Rehabilitation and Research Centre for Torture Victims \(RCT\)](#)
- Reference lists of reviews emerging from the searches
- Reference list of the final set of included studies
- Table of Contents from the top 10 most frequently cited sources emerging from the search (expected to be journal issues).

Search terms

The search terms will be deliberately broad, as many studies are conducted in non-Western, non-academic settings, with diverse reporting structures. The following strategy will be employed on the main bibliographic databases: (Population + RCT filter) OR (Population + Intervention). The search terms for PsycINFO (as indicated in [Appendix 2](#)) will be adapted for each respective database.

Grey literature

In order to identify relevant grey literature, the RCT library and OPENSIGLE were included in the list of databases to be searched. In addition, a range of publication types like reports, conference papers, posters, monographs and anthologies will be included in the search.

Reference manager software

The references will be managed using the bibliographic software EndNote.

Data collection and analysis

Selection of studies

Study selection has two stages.

1. An initial screening of titles and abstracts using the inclusion criteria, with the aim of identifying studies which may be eligible and for which the full paper should be obtained. Where abstracts are not available electronically the full paper will be sought.

2. The full papers will be read and selected against the inclusion criteria by two of the authors [BK, AW] independently. The final list will be achieved after comparison, and disagreements will be resolved by discussion; where there continues to be doubt or difference, the third reviewer [NP] will be consulted to achieve consensus.

If full details can be obtained from the authors, conference abstracts will be included, as relevant material is often published by torture survivor centres themselves. Where there is an indication that there are data in conference publications and the contact with authors is unsuccessful, such studies will be indicated in a separate section labelled 'studies awaiting classification'.

Data extraction and management

A data extraction form is in the process of being designed using as a model data extraction protocols from similar reviews.

- Study design
- Setting of intervention
- Type of interventions
- Intervention protocol
- Sample size at baseline and outcome assessments
- Baseline characteristics of the sample (age, gender, nationality, ethnicity, type of torture experienced, legal status if refugees and asylum seekers, living situation, separation from close family members)
- Baseline measures
- Type of practitioner/therapists
- Language/s of assessment; translation, interpretation

- Properties of baseline measures (language, translation, validity)
- Outcome measures at end of intervention(s) and at any follow-up assessment
- Completion rates
- Adherence, participation in treatment
- Risk of bias of included studies

Data will be extracted by two of the reviewers [BK, AW] independently, and disagreements will be resolved by discussion. Where there continues to be doubt or difference, the third reviewer [NP] will be consulted to achieve consensus.

Assessment of risk of bias in included studies

Risk of bias will be assessed for each included study using the Cochrane Collaboration 'risk of bias' tool (Higgins 2008) and issues raised around studies of psychological treatment in systematic reviews (Yates 2005). The following domains will be considered:

1. Sequence generation: was the allocation sequence adequately generated by a method unrelated to recruitment decision?
2. Allocation concealment: was allocation adequately concealed?
3. Since psychological treatments cannot blind personnel, and can rarely blind participants, assessment of bias will be made using (a) equivalence of treatment expectations of participants across arms of the study; (b) presentation of third party outcome assessments where the third party is blind to treatment allocation?
4. Incomplete outcome data for each main outcome or class of outcomes: were incomplete outcome data adequately addressed?
5. Selective outcome reporting: do the results presented match the assessments described?
6. Other sources of bias: was the study apparently free of other problems that could put it at a high risk of bias? Additional items included here are therapist qualifications, treatment fidelity, and researcher allegiance/conflict of interest.

The risk of bias will be assessed independently by two review authors (BK and AW), who will then reach consensus on their decisions, with any remaining disagreements referred to the third author (NP). If necessary, further information will be sought from study authors.

Assessment of risk of bias will use three categories: low risk, unclear (information not provided or effect not clear), and high risk. A risk of bias table will be constructed for each study. Additionally, forest plots will be ordered by risk of bias to examine for systematic effects on outcome.

Measures of treatment effect

Dichotomous outcomes (improved/not improved) will be analysed using odds ratios with 95% confidence intervals. Categorical outcomes with more than two categories (such as improved,

same, worse) will be re-categorized into two groups. We will not calculate NNTs.

Continuous data will be analysed using standardised mean differences (SMDs or effect sizes) using pooled standard deviations and weighting for sample size, and calculating the 95% confidence interval. Self- or other-rating scales risk producing severely skewed data, that is, where they produce a value between -1 and +1 when the difference between the scale maximum or minimum and the mean is divided by the standard deviation. Where data are severely skewed, they will be normalised where possible by transforms, or if this does not produce a satisfactory distribution, will be dichotomised. SMDs will then be interpreted individually with reference to the quality and reliability of the measure where available.

If authors are willing to provide raw data, clinical cutpoints (for PTSD caseness, for example) can be applied. In the much more likely event that raw data are unavailable, we will apply the methods described by Preston 2000; inverse variance weights using the standard error. It remains likely that some severely skewed data will have to be excluded from analyses.

Both dichotomous and continuous data analyses will be displayed using forest plots.

Unit of analysis issues

Multiarmed trials

If there are two or more treatment or comparison groups, we will analyse them separately by splitting the control group equally between the treatment groups (Higgins 2008a).

Cluster randomised controlled trials

In the case of cluster randomisation, we will adjust for the effects of clustering using an ICC.

Dealing with missing data

Authors will be contacted to request missing data, such as standard deviations. Loss and exclusion of data will be examined to try to understand the reasons and implications, and if appropriate, a method such as last observation carried forward may be used. Where standard deviations are missing and unobtainable from authors, we will calculate where possible from F, t, or p values, or from standard error. If this is not possible, the trial will be treated as having no useable data.

We will identify intention to treat analysis as an important marker of effort to reduce bias (see [Assessment of risk of bias in included studies](#)).

Available cases analyses will be included but interpreted with caution.

Assessment of heterogeneity

High levels of heterogeneity are likely where there are sufficient trials for meta-analysis. Where this is suggested by the forest plot (as poor overlap of confidence intervals and presence of outliers) and there is an I^2 statistic of over 40%, it will be interpreted using Higgins 2003, with reference to in/consistency in the direction of effects, and with particular reference to variation between studies in treatment aims and methods which might suggest that the set should be split.

Assessment of reporting biases

The following steps will be undertaken to address reporting biases which might otherwise operate, particularly in relation to studies in under-resourced settings and reported in the grey literature. Searches in a range of databases including those in languages other than English and those listing non peer reviewed journals; systematic search of the reference lists of reviews in the field and final included studies; manual search of the content pages of the top ten sources of publications yielded from the search; search of databases for registered trials which could yield published and unpublished studies; and the inclusion in the review of any eligible unpublished as well as published studies.

For eligible studies, a search will be made specifically for published protocols.

Data synthesis

RevMan 5 software will be used to conduct meta-analysis where feasible and appropriate. A random-effects model will be used given the various sources of diversity described above. Where meta-analysis is not possible, a narrative summary of evidence relating to the primary and secondary objectives will be provided.

We will summarise separately those studies involving direct psychological interventions with individuals, couples, families or groups. Where studies include both adult and child participants, they will be analysed to the predominant age group, or included in both analyses as appropriate.

Subgroup analysis and investigation of heterogeneity

1. Child and adult studies will be analysed separately. This is because methods and outcomes differ very substantially, as does usually the type of torture experienced.

2. If there are sufficient trials, we will separate studies conducted on populations whose members still reside in their own homes vs those who remain in their country of origin but are internally displaced vs those who are refugees. The difficulties and dangers of flight and of settling into a refugee camp or a country where asylum has been sought compound and add to the existing problems and stresses on the torture survivor. While these are hard to separate on an individual level, it makes sense where possible to recognise them at a trial level.

Sensitivity analysis

Where possible, sensitivity analyses will be used to assess the effect of the different methodological decisions made throughout the review process. These decisions will be tested by successively removing:

1. quasi-RCTs to leave only RCTs;
2. cluster-randomised trials to leave individually randomised trials;
3. trials using non-ITT methods to leave only those analysed using ITT (to be considered ITT analysis the analysis must include all participants who entered treatment, whether or not they provided data at the end of treatment). Nuesch 2009 has found that trials with intention to treat analyses produce smaller treatment effects in meta-analyses, and this difference is greater in meta-analyses in the presence of heterogeneity; and
4. unpublished trials. Some treatment studies in this literature are published in non peer-reviewed sources, such as chapters and internal reports of NGOs. To address concerns about differences in quality between the two types of sources, sensitivity analyses will be undertaken, restricted to those studies in peer-reviewed journals.

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- * Indicates the major publication for the study

APPENDICES

Appendix I. CCDAN TOPICS LIST - PSYCHOLOGICAL INTERVENTIONS

- BEHAVIOR THERAPY / BEHAVIOR MODIFICATION
 - ACTIVITY SCHEDULING
 - ASSERTIVENESS TRAINING [CINAHL]
 - AVERSION THERAPY [APA]
 - ◊ COVERT SENSITIZATION [APA]
 - BEHAVIOR CONTRACTING [CINAHL]
 - BEHAVIOR MODIFICATION
 - BIOFEEDBACK, PSYCHOLOGY [MeSH]
 - ◊ FEEDBACK, SENSORY [MeSH]
 - CONTINGENCY MANAGEMENT [CINAHL]
 - CONVERSION THERAPY [APA]
 - DISTRACTION THERAPY

- EXPOSURE THERAPY (APA)
 - ◇ Abreaction Therapy
 - ◇ Sensitivity Training
 - ◇ Systematic Desensitization Therapy (APA)
- Eye Movement Desensitization Reprocessing [MeSH]
 - ◇ Implosive Therapy [APA, MeSH]
- PLEASANT EVENTS
- PSYCHOEDUCATION
- PROBLEM-FOCUSED
- RECIPROCAL INHIBITION THERAPY (APA)
- RELAXATION TECHNIQUES [CINAHL]
 - ◇ Autogenic Training
 - ◇ Distraction [CINAHL]
 - ◇ Guided Imagery [CINAHL]
- RESPONSE COST (APA)
- SLEEP PHASE CHRONOTHERAPY [MeSH]
- SOCIAL SKILLS TRAINING
 - ◇ Social Effectiveness
- COGNITIVE BEHAVIORAL THERAPY [APA]
 - PROBLEM SOLVING
 - RATIONAL EMOTIVE THERAPY
 - REALITY THERAPY
 - RESTRUCTURING
 - ROLE PLAY
 - SCHEMAS
 - SELF-CONTROL
 - STRESS MANAGEMENT
- THIRD WAVE COGNITIVE BEHAVIORAL THERAPIES
 - Acceptance and Commitment Therapy (ACT)
 - BEHAVIORAL ACTIVATION
 - Cognitive Behavioral Analysis System of Psychotherapy (CBASP)
 - Compassion-focused
 - DIALECTICAL BEHAVIOR THERAPY (APA)
 - DIFFUSION
 - FUNCTIONAL ANALYTIC PSYCHOTHERAPY (FAP)
 - METACOGNITIVE THERAPY
 - Mind Training
 - Mindfulness
- PSYCHODYNAMIC THERAPIES
 - BRIEF PSYCHOTHERAPY
 - COUNTERTRANSFERENCE
 - FREUDIAN
 - GROUP THERAPY
 - ◇ Balint Group Therapy
 - INSIGHT ORIENTED THERAPY
 - JUNGIAN
 - KLEINIAN
 - OBJECT RELATIONS
 - ◇ Person Centred Therapy, Client-Centred Therapy
 - PSYCHOANALYTIC THERAPY
 - ◇ Alderian Therapy
 - ◇ Dream Analysis
 - ◇ Free Association

- ◇ Self Analysis
 - SHORT-TERM PSYCHOTHERAPY
 - TRANSFERENCE
- HUMANISTIC THERAPIES
 - EXISTENTIAL THERAPY
 - EXPERIENTIAL THERAPY
 - ◇ PROCESS-EXPERIENTIAL
 - ◇ GESTALT THERAPY
 - EXPRESSIVE THERAPY
 - GRIEFWORK
 - ROGERIAN
 - Non-directive Therapy
 - SUPPORTIVE THERAPY
 - Transactional Analysis
- INTEGRATIVE THERAPIES
 - COGNITIVE ANALYTICAL THERAPY
 - COUNSELLING
 - ECLECTIC THERAPY
 - INTERPERSONAL THERAPY
 - ◇ Psychodynamic Interpersonal Therapy
 - MULTIMODAL
 - TRANSTHEORETICAL
- SYSTEMIC THERAPIES
 - CONJOINT THERAPY
 - ◇ COUPLES, MARITAL OR RELATIONSHIP THERAPY
- EMOTION FOCUSED THERAPY
 - ◇ FAMILY THERAPY
 - Integrative Behavioral Couple Therapy (IBCT)
 - NARRATIVE THERAPY
 - Personal Construct
 - Socioenvironmental Therapy
 - ◇ Milieu Therapy
 - ◇ Therapeutic Community
 - SOLUTION FOCUSED BRIEF THERAPY
- OTHER PSYCHOLOGICALLY-ORIENTED INTERVENTIONS
 - ACTING OUT
 - AGE REGRESSION THERAPY
 - ART THERAPY
 - BIBLIOTHERAPY
 - CATHARSIS
 - COLOUR THERAPY
 - CRISIS INTERVENTION
 - DANCE THERAPY
 - DRAMA THERAPY
 - EMOTIONAL FREEDOM TECHNIQUES
 - HYPNOTHERAPY
 - ◇ Autosuggestion
 - ◇ Neuro-Linguistic Programming (NLP)
 - ◇ Persuasion
 - Meditation [CINAHL]
 - MORITA THERAPY
 - MUSIC THERAPY
 - PLAY THERAPY

- PRIMAL THERAPY
- PSYCHODRAMA
- REMINISCENCE THERAPY
- SEX THERAPY

Appendix 2. OVID PsycINFO Search (1806 - to date):

Population: Torture survivors

1. Torture/
2. Prisoners of War/
3. torture\$.tw.
4. (trauma\$ and asylum\$).mp.
5. (surviv\$ adj7 war).mp.
6. (polit\$ adj7 persecut\$).mp.
7. or/1-6

Study filter: RCT

8. clinical trials.sh.
9. mental health program evaluation.sh.
10. treatment effectiveness evaluation.sh.
11. placebo.sh.
12. placebo\$.ti,ab.
13. randomly.ab.
14. randomi#ed.ti,ab.
15. trial.ti,ab.
16. ((singl\$ or doubl\$ or trebl\$ or tripl\$) adj3 (blind\$ or mask\$ or dummy)).mp.
17. (control\$ adj3 (trial\$ or study or studies or group\$)).ti,ab.
18. factorial\$.ti,ab.
19. allocat\$.ti,ab.
20. assign\$.ti,ab.
21. (crossover\$ or cross over\$).ti,ab.
22. (quasi adj (experimental or random\$)).mp.
23. "2000".md. [methodology=treatment outcome/clinical trial]
24. or/8-23

Intervention: Psychosocial

25. 3300.cc. [Concept Code:Health & Mental Health Treatment & Prevention [3300]]
26. exp Psychotherapy/
27. exp Psychotherapeutic Processes/
28. (psychotherap\$ or psychoeducat\$ or psychodrama\$ or psychoanaly\$).mp.
29. (abreaction or acting out or anger control or anger management or autosuggestion or balint group or befriend\$ or behavior\$ or biofeedback\$ or client cent\$ or contingency manage\$ or countertransference or discussion group\$ or emotion\$ focus\$ or healing or insight\$ or interpersonal or mentor\$ or operant\$ or paradox\$ or problem solv\$ or reinforcement\$ or role play\$ or stress manage\$ or therap\$ or train\$ or transactional).tw.
30. Couples Therapy/ or exp Family Therapy/ or Group Psychotherapy/
- 31, exp Interpersonal Relationships/
32. exp Counseling/
33. counsel\$.tw.
34. exp Coping Behavior/
35. exp Coping Behavior/
36. ((coping or adjust\$) adj3 (skill\$ or mechanism\$)).tw.
37. Psychosocial Factors/

38. Psychosocial Readjustment/
39. exp Rehabilitation/
40. (psychosocial\$ or psycho-social\$).tw.
41. (rehabilitat\$ or resociali\$ or re-sociali\$).tw.
42. Social Adjustment/
43. Social Interaction/
44. exp "assistance (social behavior)"/
45. Sociocultural Factors/
46. Social Skills Training/
47. Health education/
48. (communit\$ or educat\$ or housing or social\$ or socio\$ or welfare\$).tw.
49. Quality of Life/
50. Self Esteem/
51. (self analys\$ or self esteem).tw.
52. "Trust (social behavior)"/
53. Support Groups/
54. Treatment/
55. exp Intervention/
56. Interdisciplinary Treatment Approach/
57. exp Mental Health Services/
58. exp Case Management/
59. or/25-58
- Combined searches**
60. (7 and 24) or (7 and 59)

HISTORY

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CONTRIBUTIONS OF AUTHORS

BK will manage the overall review process, do the searches, select studies, author sections of the manuscript, extract data, undertake analysis, and code papers.

AW will select studies, author sections of the manuscript, extract data, undertake analysis and code papers.

NP will author sections of the manuscript and resolve differences in selecting papers and coding.

DECLARATIONS OF INTEREST

NP and AW are clinical practitioners as well as academics: both work clinically with torture survivors but neither has conducted a treatment trial.

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External sources

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