CSVR

The Centre for the Study of Violence and Reconciliation

Why do clients stay in counselling: A comparitive analysis of why clients stay for a short or long time using CSVR's psychosocial services

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Restoring the Dignity of the Human Spirit

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ACKNOWLEDGEMENTS

This report would not have been possible without the participation of our clients who have experienced severe traumas. Their resilience and strength amidst their difficulties continue to inspire us. We hope that this work in some way assists them and others in their journey towards recovery.

Without the work of numerous people, this report would not have been possible. Thanks to the clinicians at CSVR who allowed us to make their work "public". Their acceptance and use of the M&E system has allowed us to start to understand the work that we are doing in the clinic, and use this to make our work better. Thank you as well, for allowing us to analyse the very personal spaces contained within the process notes, to fully understand what is happening in the therapeutic space. Thank you to Sumaiya Mohamed who discussed the analysis and provided thoughts and guidance to make it better.

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Our receptionists are usually the first people that clients meet when coming into the clinic. Sonto Mbatha plays a central role in ensuring that clients felt welcome and respected throughout the duration of their therapeutic relationship with us.

As a number of our clients come from other African countries, interpreters are necessary during the therapeutic processes and in order to complete the M&E instruments. Gaudence Uwiyeze coordinates our interpreters. We thank all of the interpreters who have been key to the ensuring synergy in the therapeutic spaces. These interpreters provide support to clients who communicate in other languages and play an important role in the therapeutic process with clinicians as well as in gathering data for M&E.

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BACKGROUND

The Centre for the Study of Violence and Reconciliation (CSVR) is a multi-disciplinary institute whose primary goal is to use its expertise in building reconciliation, democracy and a human rights culture, and in preventing violence in South Africa and other countries in Africa.

The CSVR began offering a free counselling service to victims of political violence in 1989. Since the mid-1990s we have seen a shift from political violence to criminal violence within the country. From the late 1990s, the CSVR began counselling refugees and asylum seekers, individuals and groups from various African countries who had experienced violent conflict in their home countries and/or violence in South Africa.

With the support of Dignity since 2007– formerly the Rehabilitation and Research Centre for Torture Victims (RCT) - and the USAID from the third quarter of 2011, the CSVR has embarked on a project aiming to strengthen the struggle against torture in South Africa and the African region. One of our objectives is to develop a comprehensive Client Information and Monitoring and Evaluating (M&E) system for the psychosocial services provided to victims of torture. The development of the M&E system itself was informed by current theory and achieved through collaboration between clinical staff, researchers, external consultants, and Dignity staff. The system has changed over time to accommodate challenges encountered through implementation.

As the aims of M&E include the creation of spaces for reflection and learning, it is hoped that this process will help us learn more about our interventions and assist clinicians in improving their services to victims of torture. It also allows us to gather data on victims of torture[1] within our context.

[1] "Torture" is used in this document to denote the range of experiences of abuse which the United Nations Convention Against Torture (1984) defines as torture and cruel, inhumane and degrading treatment (CIDT). This convention defines torture as:

> "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 which he or a third person has 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 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"

As Bantjes and Langa (2011, p.7) state,

> "Often there is a fine line between incidents that meet the legal criteria for torture and those that are considered cruel, inhumane and degrading treatment under international law. Furthermore, an incident can start off as CIDT and escalate into torture."

For this reason, we choose not to differentiate between torture and CIDT for our clinical interventions, and so, for the purposes of this report, "torture" may connote any of the experiences that fall between CIDT and torture.

Describing the Client Information and Monitoring and Evaluation Process:

After going through a screening process[2], a client has one session with his/her counsellor in order to receive immediate support and containment, after which a more comprehensive baseline interview[3] is completed.

At the time that the data was analysed for this report, CSVR used a session-based time-frame for the completion of assessments: After every six sessions, the client is asked to complete a self-assessment to assess his/her improvement in functioning or reduction in symptoms. In 2014 this has been updated towards a time-frame of three months between assessments.

After every session, the clinician should complete a counselling Intervention Process Note (IPN). Additionally, all interventions should be captured on our database under the IPNs. This includes referrals and telephone calls made; follow-ups from other centres and telephone calls received, consultations with the interpreter or colleagues, and escorting the client to the hospital or assisting the client with interpretations. When counselling ends, the clinician should complete a Termination Intervention Process Note (Termination IPN).

The information that comes out of the M&E process has been used to inform individual client sessions through Client Progress Reports (CPRs). The Client Progress Reports give an indication of the client's change in both symptoms and functioning over time. CPRs can only be produced once a client has two or more client-assessments. Each CPR includes the PTSD, Self-perception of functioning, anxiety and depression scores; as well as an indication of the change in the client's isolation, locus of control questions, and functioning indicators that the clinicians felt were important to observe change on. These different indicators are then put into line graphs in order to give a visual representation of the client's functioning and symptoms over time. Examples of this can be seen in the annual M&E reports (see for instance, Dix-Peek, 2011).

Additionally, this information has been used to report back to the internal staff as well as external organisations, the impact and change seen in the clinic through the annual reports from 2009-2011 (see for instance, Dix-Peek, 2011).

Rationale

In order to improve the quality of practice within CSVR regarding torture rehabilitation services, we need to generate knowledge from the information that we collect. In this section, we attempt to understand whether or not there is a difference between clients who stay for medium to long term counselling (19 sessions or more) and those who are considered to be

[2] The screening process obtains information about the client's demographic information as well as a brief description of the traumatic event(s).

[3] Information regarding the baseline and client assessment interviews will be described in the Methods section

early leavers (clients who have two sessions or less) so that we can understand how best to intervene. Conventional trauma-focused therapy usually lasts between 8 to 12 sessions. Given that the impacts of torture may affect different aspects of the client, we include sessions up to 18 sessions in the category of conventional therapy.

Because of the complex nature of torture and the impact that torture has on an individual, CSVR has chosen not to have a set number of sessions before termination. For this reason, clients may terminate counselling early on in the counselling process (what this report calls early leavers), or may stay for years without terminating counselling. While each case needs to be understood in its own merits, neither of these extremes (very short term counselling or very long-term counselling) are considered ideal for the therapeutic process. Arguably, little is achieved when a client is an early leaver. Often these sessions are used to establish trust and ensure rapport is built with the client. On the other hand, clients who stay for too long may be over-reliant on the services provided in the therapeutic process.

The aims of this study are to understand:

- Is there a difference between clients who stay for a very short period of time and those who stay for a long period of time?
- Can we identify clients who are early leavers?
- Can we identify clients who stay for a long period of time?
- In what way should we intervene with both of these population groups in order to ensure that clients are able to engage with the therapeutic process?

Hypotheses:

This report hypothesises that clients who stay longer in counselling will likely be more complex cases with decreased resilience and protective factors. This is contrasted to clients who stay for a short period in counselling who will likely be less complex cases with increased resilience and protective factors.

Complex cases include clients who have:

- Complex, and clinical levels of, Posttraumatic Stress Disorder (PTSD)
- Higher anxiety and depression scores
- Less functioning

Complex cases include clients who experienced:

- More forms of torture
- More types of traumatic events
- Traumatic events that are considered more “severe” societally, such as rape, war, traumatic bereavement
- Torture events that are considered more “severe” societally, such as sexual torture

Resilience and protective factors include

- Social support
- Education levels
- Employment levels
- Age at time of trauma
- Gender

Limitations:
It is noted that a primary limitation of this report is that it does not include the information for clients between 3 and 18 sessions. This information has not been forgotten. Rather, due to the fact that this report attempts to understand the two extremes in the clinical process (i.e., the early leavers (clients who stay for two sessions or fewer), and clients who stay for a long period of time in counselling (those who stay for 19 sessions or more), we chose to leave the middle sample out of this analysis. This report is not attempting to understand trends in the therapeutic process, but rather understand the two extreme groups.

Literature review: Protective factors, resilience and risk
As mentioned previously, this report hypothesises that clients who stay longer in counselling are likely to be more complex cases that include more severe psychiatric symptoms, worse functioning, more numbers of traumatic and torture events, more severe traumatic and torture events and more areas of pain. This report further hypothesises that clients who stay longer in counselling will be associated with more risk factors such as less social support, lower education and employment level, younger age at time of trauma, and likely to be female.

While there are various definitions of resilience, the definition provided by Arnetz et al (2013, p.167) gives a sufficient indication of how we view resilience. According to them, resilience is defined as:

> … traits that help protect against the psychological disorders resulting from exposure to terrifying incidents, such as mass violence or deportation under life-threatening circumstances[4]; it encompasses bouncing back and positive adaptation in the face of safety-challenging experiences"

Protective factor relates to resilience, looking at the individual factors that play a role in understanding why psychiatric conditions do not occur following exposure. Risk factors are the "individual vulnerability factors" that play a role in understanding why psychiatric conditions (such as Posttraumatic Stress Disorder (PTSD), anxiety and depression) occur following the exposure to a traumatic event (Brewin et.al. 2000, p.748).

The literature indicates that resilience and protective factors include age at time of traumatic event, increased social support, increased employment status and higher education. Female

[4] We include torture in the categories of terrifying incidences

gender is seen to be a risk factor (i.e., women are more likely to have psychiatric symptoms such as PTSD, anxiety and depression) (Arnetz et.al., 2013; Silove et. al., 2010; Silove et.al., 1997; Ahern & Galea, 2006).

Traumas that carry a high risk for traumatisation and psychiatric conditions, for example, rape or sexual violence and bereavement or traumatic bereavement, is a risk factor for traumatisation (Blair, 2000; Shalev et. al, 1996; Brewin et al, 2000). In addition to the types of traumas, an increased number of traumatic events is seen to be a risk factor for traumatic responses (Hirini et.al, 2005).

There are few scholarly articles to observe the impact of different nationalities on traumatic symptoms, however, many articles indicate that being a refugee in a host country will impact a person's emotional and psychological wellbeing as well as their ability to negotiate the landscape of the host country. These clients are likely to have less resilience and fewer protective mechanisms (Bandeira et al, 2010; Hooberman et al, 2010, Montgomery, 2010, Higson-Smith et al, 2007)

1. Methods

The data presented in this report is part of a more comprehensive Monitoring and Evaluation (M&E) and client information system. It was initially introduced in 2007 through consultation with clinical staff, researchers, external consultants and staff at the Research and Rehabilitation Centre for Victims of Torture (RCT) – now Dignity. Changes have been made over time to accommodate challenges experienced in the implementation process.

All clients who had terminated counselling between 2007 and 2013 and reported a history of torture were included in this sample. The reason that clients who had terminated counselling was chosen is because it was important that the clients would not have more counselling sessions in the future, thus impacting on their number of sessions. Clients were free to refuse to participate and were not penalised if they so chose. The baseline interviews are done either by clinicians or Masters Psychology students who have been given additional training on the assessment and support of torture survivors. All information has been captured on the M&E and client information system with client codes to ensure the anonymity and confidentiality of our clients.

A total number of 156 clients terminated counselling between 2007 and 2013. The mean number of sessions for this group of clients is 10.52 with a standard deviation of 12.71. The most number of sessions a client had was 59 and 24 clients had 0 sessions. In order to better understand what makes a difference to clients who can stay for a short period of time and those who stay for a long period of time, we divided our sample up according to number of sessions:

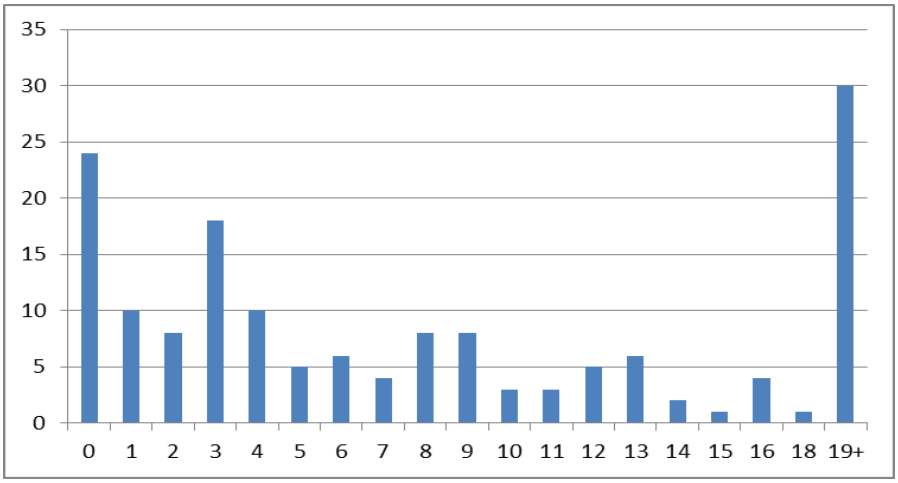

Figure 1: Frequency of clients by number of sessions

42 of the total 156 clients had 0-2 sessions before terminating counselling, and 30 clients had 19 or more sessions before terminating counselling. The clients who fall in between these two samples are the clients who are staying for what is considered a "conventional" counselling time period. Many trauma and torture rehabilitation centres will likely terminate counselling between the twelfth and eighteenth session. However, this study attempts to identify clients who will stay for a short or long period of time in counselling, in order to better provide counselling to these two groups, and in order to ensure that these clients are able to fully engage with the therapeutic process.

This report is based on the client information system, utilising the information gathered during the screening interview, and the baseline interview. The screening form includes demographic information, a brief description of the traumatic event, symptoms and reactions to this event(s). Because tortured clients experience high levels of psychiatric conditions, including post-traumatic stress disorder (PTSD), anxiety and depression, CSVR uses indicators that attempt to observe these psychiatric conditions (Quiroga & Jaranson, 2005).
The baseline assessment and client assessment forms include:

- Demographic information
- Questions regarding the physical and emotional support that clients feel is being provided by different societal members such as the police, home affairs, health professionals and family members (description given in i. below)
- The Harvard Trauma Questionnaire (HTQ), measuring Posttraumatic Stress Disorder (PTSD), clients' self-perception of their own functioning and general trauma (description given in ii. below)
- The Hospital Anxiety and Depression Scale (HADS), measuring anxiety and depression (description given in iii. below)
- Five functioning questions that emerged from the International Classification of Functioning, Disability and Health (ICF) (description given in iv. below)
- Questions regarding medical conditions, disabilities pain and substance use (description given in v. below)

i. Torture survivors often require a wide range of assistance, including psychological, social, legal, and medical. In the experience of the clinical team, the role of authority figures (such as the police and Home Affairs officials – the officials responsible for granting or denying legal status in South Africa), health professionals, and family members is important in terms of the recovery process of survivors of torture. As such, questions regarding the impact of these on their recovery were included in the assessments. Although clinical work may not be able to change how these groups treat or interact with clients, it may be able to work with clients' ability to manage these interactions. These questions also provide information on some of the contextual factors impacting on clients' recovery. The questions relating to the impact of different people on clients' recovery are scored between -2 (slow down a great deal) to 2 (support a great deal).

   In 2011, we differentiated the question about the impact of Authority figures into two constituent parts: the police and home affairs. Where a response regarding authority figures was clearly related to either the police or home affairs, this information was re-coded and included in that question. For this reason, only 38 (53%) of clients answered the question about authority figures, while 49 (68%) and 46 (64%) clients answered the questions about the police and home affairs respectively.

ii. The Harvard Trauma Questionnaire (HTQ) includes 40 symptom items. The first 16 items are linked to the Diagnostic and Statistical Manual, Fourth Edition (DSM-IV) using the stipulated sub-domains of re-experiencing traumatic events, avoidance and numbing, and psychological arousal for Post-Traumatic Stress Disorder (PTSD). Items 17-40 "aim to gauge personal perceptions of psychosocial functioning in response to the stresses of persecution, violence and displacement." (p.15). Together items 1-40 give the HTQ: Total score which indicates the levels of trauma that have been experienced. Higher scores on the HTQ Total score and PTSD scores indicate that it is more likely that a client has symptoms associated with trauma and post-traumatic stress disorder.

   PTSD and self-perception of functioning are measured on a four point scale including: not at all, a little bit, quite a bit and extremely; and assigned a value of 1, 2, 3 or 4 respectively. A score is computed for each scale by averaging the scale value for responses to all the items in the scale, allowing patients to be ordered from no symptoms to extreme symptoms based on the average score. For both the PTSD score and the self-perception of functioning score there is a maximum score of four. Mollica et al (2004) suggest a cut-off of 2.03 to be symptomatic for PTSD for clinical work with refugee populations. However, we opted for the more conservative cut-off of 2.5 to be considered check-list positive for clinical levels of PTSD. There is no cut-off for the self-perception of functioning score, however higher scores on this measure indicate lower self-perception of functioning.

iii. The Hospital Anxiety and Depression Scale (HADS) provides 14 items related to anxiety and depression. There is a maximum score of 21 for both of these psychiatric factors. The

scoring of these items reveal that scores between 0-7 indicate normal levels of anxiety or depression, 8-10 indicate borderline levels and scores of 11 or more indicate clinical levels for these psychiatric factors.

iv. CSVR asks clients five questions relating to their functioning. These indicators are adapted from the International Classification of Functioning, Disability and Health (ICF) (WHO, 2001) and were developed to assess functioning in areas the clinical team felt were important in terms of their interventions. These areas include clients' perception of their ability to:

- Solve complex problems
- Manage the tasks they need to do in a day
- Manage their symptoms
- Control their reactions to others
- Manage their connections with their family

The responses are scored according to how much difficulty the client had with that particular area of functioning, ranging from no difficulty (0) to complete difficulty (4).

v. Many torture survivors indicate that they have a medical condition and /or pain. Because CSVR does not offer medical interventions, this is not an area of focus for us. However, it is important to document medical conditions and pain, and may assist in indicating areas that clinicians need to focus on.

Information was analysed using STATISTICA to elucidate the similarities and differences between these two groups.

In order to further our understanding of whether there is a difference between clients who stay for 0-2 sessions and those who stay for 19 sessions or more, a thematic analysis of the Intervention Process Notes (IPNs) was conducted. IPNs are completed for any intervention done with a client, including individual counselling sessions with clients. These notes cover the content of the session, notes for supervision (areas of concern) and main themes to emerge from the session.

The sample of process notes was taken from any client who was included in our two samples of clients who had had 0-2 sessions or 19+ sessions. Notwithstanding the clients who had not had any sessions and thus no process note was completed for them, this came to 30 individual session IPNs for 17 clients who had had 2 or fewer sessions (40% of that sample) and 30 IPNs for 15 clients who had had 19 sessions or more (50% of that sample). The IPNs are not represented of the total population, but is rather a convenience sample of what is in the database. It is therefore not generalisable to all early leavers, or to those who stayed in counselling for a longer period of time.

The report utilises information gathered through a focus group feed-back discussion. This discussion included three clinical staff, the programme manager, a senior researcher, an M&E

officer. This researcher presented information coming out of the results and facilitated discussions. The results of this discussion are presented in a way that protects the confidentiality of the focus group members. All staff participated voluntarily in the discussion and there was no penalisation if staff members did not participate in the discussion.

As not all of our clients completed a baseline assessment between 2007 and 2013, we need to be cautious about generalising the information gathered in this report. However we find the information helpful to direct our interventions and understanding.

2. CSVR Clinical staff

There are 14 members of clinical staff who have conducted counselling with torture survivors between 2007 and 2013. These include 10 women and 4 men. The counsellors are divided according to the category of professional of the clinician. The categories of professionals include full time trauma professionals; part time trauma professionals, Master of Interns (including clinical and counselling masters); Social Work Interns; Sessional Workers (Consultant clinicians who work on a sessional basis); Volunteers. These categories are fluid, such that interns may continue their work in CSVR as sessional worker or a trauma professional (part or full time). Volunteers have continued their work as sessional workers and so forth.

Keeping this in mind, the clinicians were included in an average of 1.5 different categories of professional, with the maximum being three, and the mode being one. Due to the fluid nature of the categories of professional, the analysis of this information took into account the different roles that a clinician may play in CSVR at different times, such that if a clinician began as an intern, the category of professional was an intern. If/when the clinician became a sessional worker, the category would remain as such.

Table 1 indicates the range of number of sessions by category of professional, along with the mean and median.

Category of professional	**Range**	**Average (Std.Dev)**	**Median**
Trauma professional (full time)	0-59 sessions	12.14 (13.46)	8
Trauma professional (part time)	0-39 sessions	6.18 (8.17)	3.5
Sessional worker	0-42 sessions	9.68 (14.18)	3
Other	0-52 sessions	9.38 (7.43)	9

Table 1: Range of number of sessions per category of professional

3. Client Demographic Information

In order to give a comprehensive idea of the clients who terminated counselling between 2007 and 2013, the demographic information is broken down according to the full sample (156 clients) and then the sample of 42 early leavers and 30 clients who stayed 19 sessions or more is focused on.

The full sample of 156 clients who terminated counselling between 2007 and 2013 consists of 85 (54%) of women and 71 (46%) men. The age of this sample ranges between 15 and 57 with a mean of 34 and a median of 33 (standard deviation: 9.53). Clients came from 12 different countries, with 44 (28%) and 49 (31%) clients coming from the Congo (DRC) and Zimbabwe respectively. "Other" refers to one client from Angola, one client from Cameroon, and two clients from Kenya (figure 2 below).

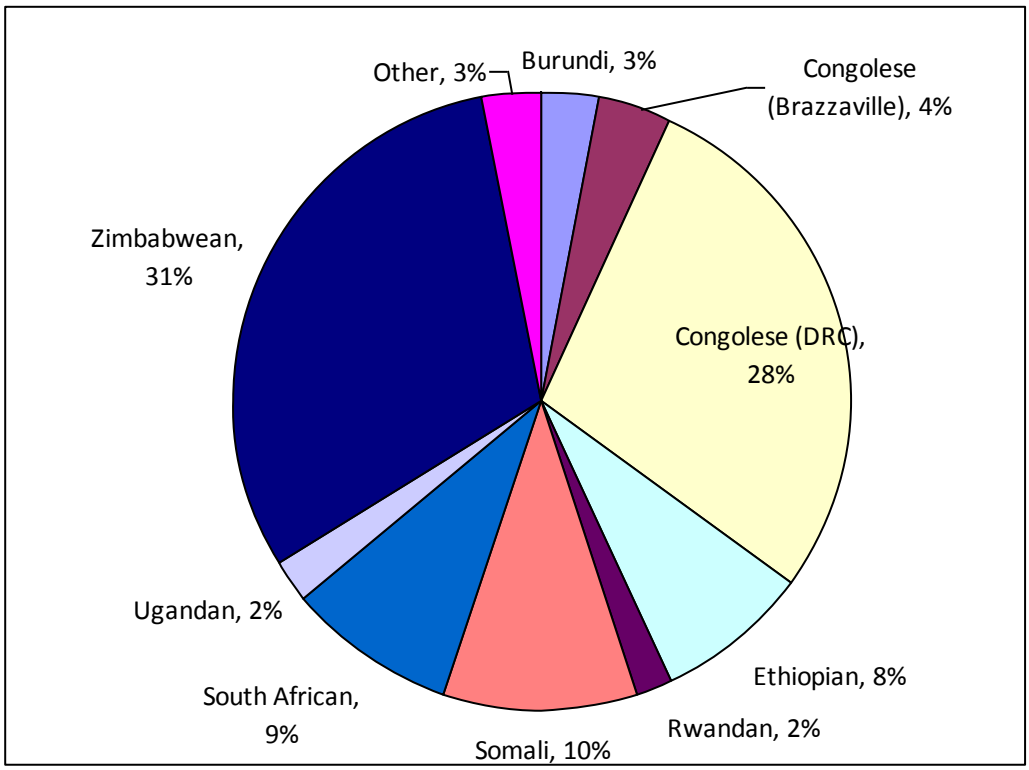

Figure 2: Nationality of total sample of clients

Clients experienced an average of two different traumatic events, with a maximum of seven. Every client experienced at least one form of torture either directly or indirectly.

Information for client's functioning was provided for 121 clients (78%). The two areas that clients reported having the most difficulty with their functioning was in solving their complex problems (58% of clients indicated that they had severe to complete difficulty in solving complex problems), and managing their symptoms (46% of clients indicated severe to complete difficulty in managing their symptoms). The figure below indicates the range of functioning for this sample.

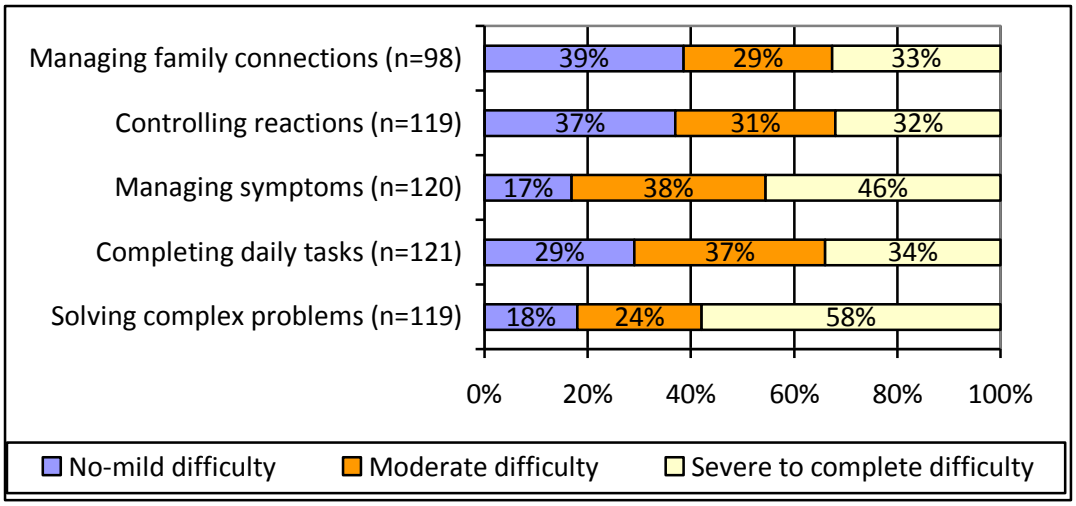

Figure 3: Functioning of clients at baseline

This sample of clients experienced clinical levels of Posttraumatic Stress Disorder (PTSD), anxiety and depression. The average PTSD score was 2.85 while the average self-perception of functioning score was 2.63. 114 clients (73%) fell above the cut-off of 2.5 for clinical levels of PTSD. The average anxiety score was 13.58 while the average depression score was 11.97. 117 clients (73%) and 97 clients (62%) fell above the cut-off of 11 for clinical levels of anxiety and depression respectively.

The demographic information for clients is broken down according to the groups of early leavers and clients who remained in counselling for 19 sessions or more below.

For the sample of 72 clients who stayed for two sessions or less, or 19 sessions or more, clients came from 11 different countries with 40% coming from Southern Africa, 25% coming from East Africa and 34% coming from Central Africa. One client came from Cameroon (figure 4).

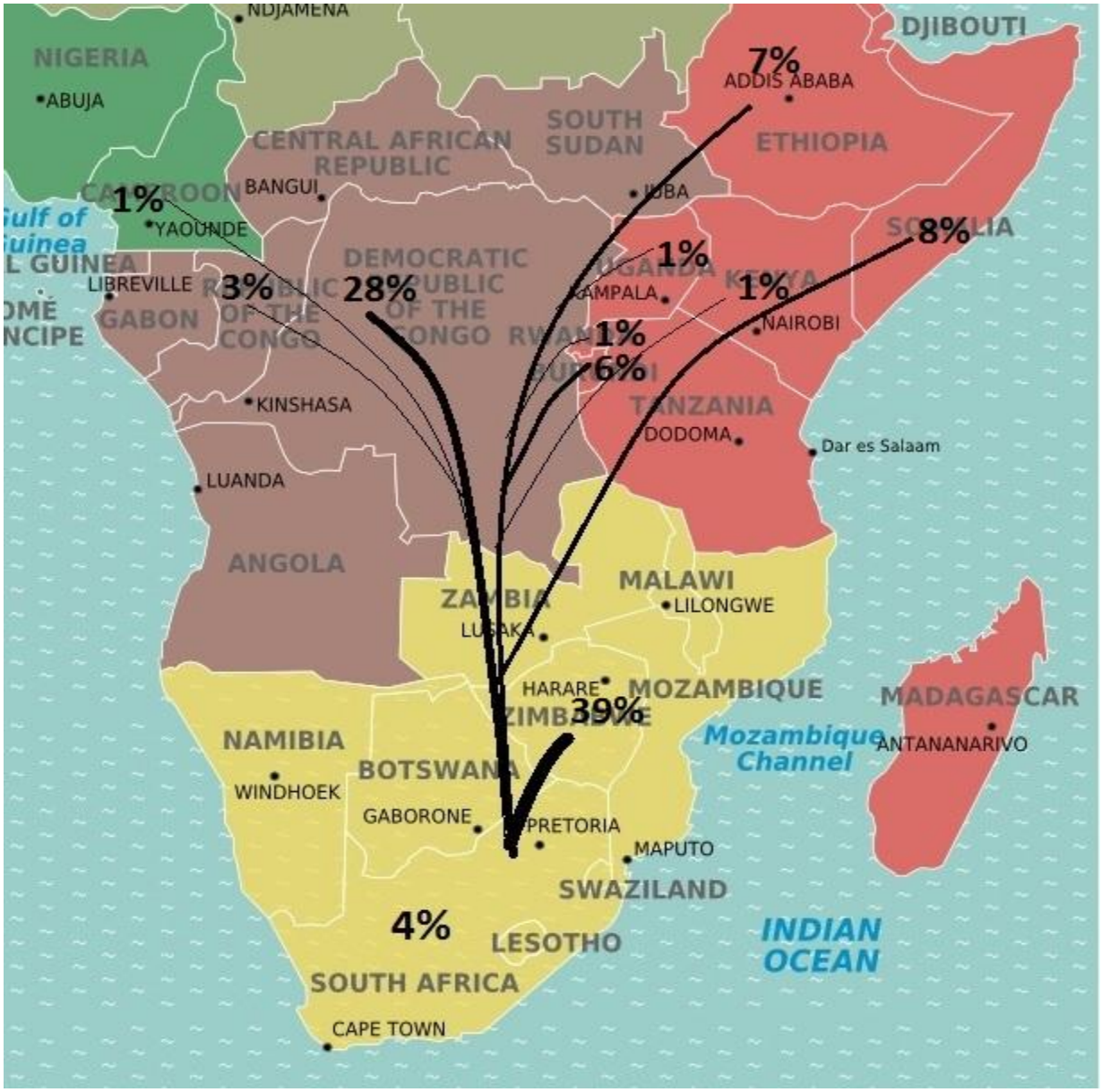

Figure 4: Nationality of clients by region

The oldest client was 57 years of age, while the youngest was 17. The mean age of this sample was 34, with a median of 31. The standard deviation was 8.97 for the clients' ages. The majority of clients who are included in this sample were female (54%). The following figure gives a breakdown of gender by number of sessions[5].

[5] Unless otherwise stipulated, the percentage is indicated on the y-axis for all graphs, and the number is indicated within the columns

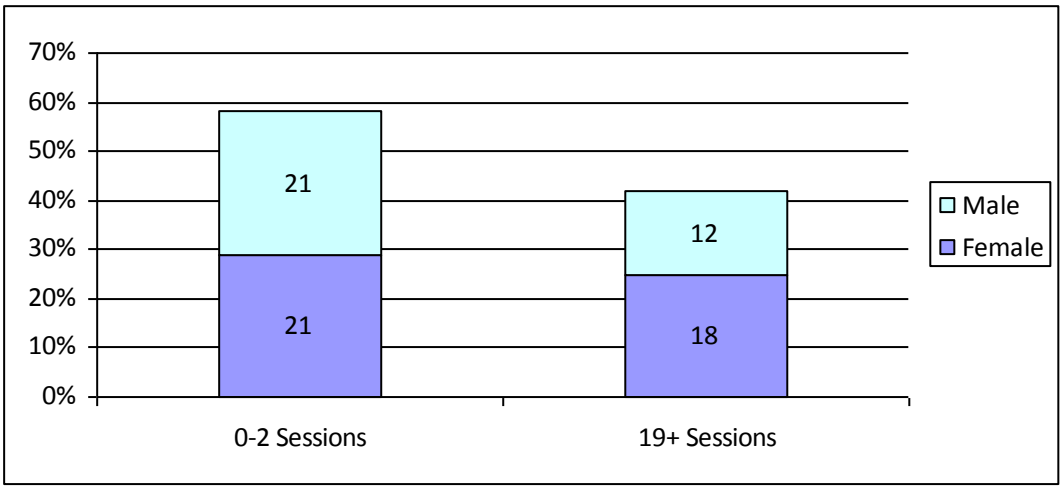

Figure 5: Breakdown of number of sessions by gender

40% of the 65 clients who specified their marital status had never been married at the time of the baseline assessment while just over one third (34%) reported being married (figure 6).

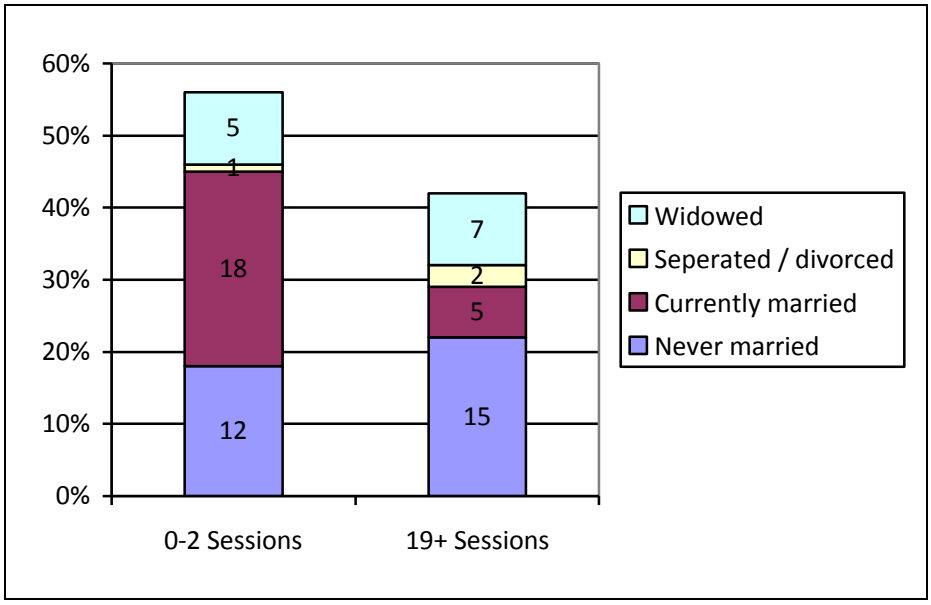

Figure 6: Marital status broken down by number of sessions

Just over a third of the clients (35%) were living with their family (which includes living alone with their children) while 28% were either living with strangers or in a shelter. The rest of the clients were either living alone (13%), with friends (20%) or with their partner or spouse (9%).

Seventeen clients (24%) reported having no children at the time of the screening interview, while 13 clients did not mention whether or not they had children. The other 42 clients had

between one and seven children. The mean number of children was 2.4, while the median was 2 (s.d.=1.49).

47 (72%) of the 65 clients who had specified their education level had completed a high school level education or above. 27 (42%) had a tertiary level or post-graduate level education. Before the torture experience, 62% were employed in either skilled or highly skilled/professional positions (n=66) while 12% were unemployed. However, at the time of intake, 50 clients (71%) were unemployed (n=70) (figure 7).

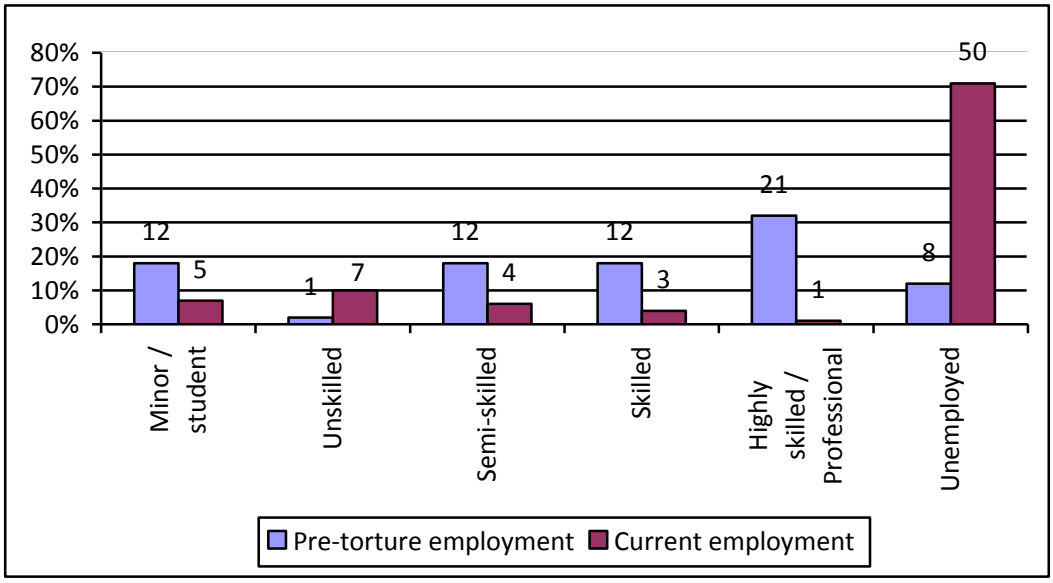

Figure 7: Changes in employment status linked to torture for all clients included in sample

An area of concern for clinicians when counselling tortured clients, is the clients' legal status in South Africa. Many of our clients are refugees and asylum seekers or have no legal documentation in South Africa. Clients who are undocumented are at risk because they have more possibility of being picked up by the South African Police and put into prison or taken to Lindela Repatriation Centre (a holding centre for undocumented migrants and foreign nationals while awaiting the determination of their legal status or deportation from South Africa). Additionally foreign nationals (whether documented or not) are at greater risk of being forced to pay bribes to the police or Home Affairs officials in order to prevent deportation and ensure that they do not have to go to prison or get their legal papers confiscated.

CSVR only began capturing information about clients' legal status in South Africa in 2011, so there is only information on legal status in South Africa for 22 (31%) of our clients. However, for those who do have this information captured, 95% of clients were asylum seekers, refugees or were without documentation. The other 5% of clients were South African citizens.

4. Results

Does the counsellor make a difference to how long a client stays in counselling?

There is evidence to suggest that who a client's counsellor is will make a difference to how long the client stays (X^2=38.78; df=21; p=0.01). Additionally, the category of professional (for example, full time trauma professional, part time trauma professional, sessional worker, intern and volunteer) also impacts how long a client stays for counselling (X^2=22.58; df=6; p=0.001), with clients more likely to drop out between 0-2 sessions if they have been seen by a category of professional that is not a full time or part time trauma professional.

The gender of the clinician does not make a significant difference to how long a client stays in counselling (X^2=3.28, df=1, p=0.07). The results from this small sample approach statistical significance and so warrant further investigation.

Do reasons for termination provided by the clinician make a difference to length of stay in counselling?

After a client terminates counselling, the clinician indicates the reason for termination. This information is included as part of the intervention process notes, as well as on the administration section of the screening form. A drop-down menu with possible reasons are included in both of these forms. These include:

- The client dropped out without giving a reason
- Client can no longer attend counselling because [s/he] got a job or moved somewhere
- Client terminated counselling
- Counsellor terminated counselling
- Mutual agreement that counselling was successful
- Mutual agreement that counselling is not working

Because almost no clients with 0-2 sessions gave mutual reasons for termination or counselling being successful, this information focuses on the two areas:

- Client stopped coming without giving a reason
- Client can no longer attend counselling (got a job or moved somewhere)

The reasons a client stops coming for counselling is significantly related to how long a client stays (X^2=4.359, df=1, p=0.037). This indicates that a client is more likely to terminate counselling without giving a reason if s/he has had two sessions or less, while a client is more likely to terminate because s/he found a job or moved somewhere if s/he had had 19 sessions or more.

Does demographic information make a difference to length of stay in counselling?

When looking at clients' demographic information, there are very few areas that impact whether a client stays for a longer period of time (19 sessions or more) compared to those who terminate counselling after two sessions or less.

Of the demographic information asked for in the screening process, only marital status and education was significant (Table 2).

Demographic information	X^2	**df**	*p*
Gender	0.733	3	0.8654
Region of nationality	4.748	6	0.5765
Marital status	24.316	9	0.0038
Education	5.850	1	0.0156
Employment status	10.541	9	0.3085
Change in employment level	4.385	3	0.2228
Legal status in South Africa	7.297	6	0.2943
Who client is living with	12.358	12	0.4174

Table 2: Chi-square relating demographic information to the number of sessions clients had (significant at p=0.05)

There is no statistical correlation between how long a client stays in counselling and how many children s/he has (t=0.833; df = 40 p=0.409). Additionally, neither the age of a client at baseline, or the age of client at time of trauma[6] makes a difference to how long the client stays in counselling (For age at baseline, t=0.22; df=70; p=0.83. For age at trauma, t=0.26; df=55; p=0.79).

As can be seen from the figure below, clients with a longer time since the traumatic event tended to stay for longer periods of time. However, statistically, there is no indication that time since the trauma impacts how long s/he stays in counselling (X^2=14.542; df=9; p=0.104).

[6] Age at time of trauma was not specifically asked during the screening or baseline assessment. As CSVR does record age and time since trauma, these numbers were worked out using the categorical scale of how long it had been since a client came in for counselling. Because this is given as a continuous scale rather than dates, average time was used. For this reason, further research into this information should be done before any conclusions can be drawn.

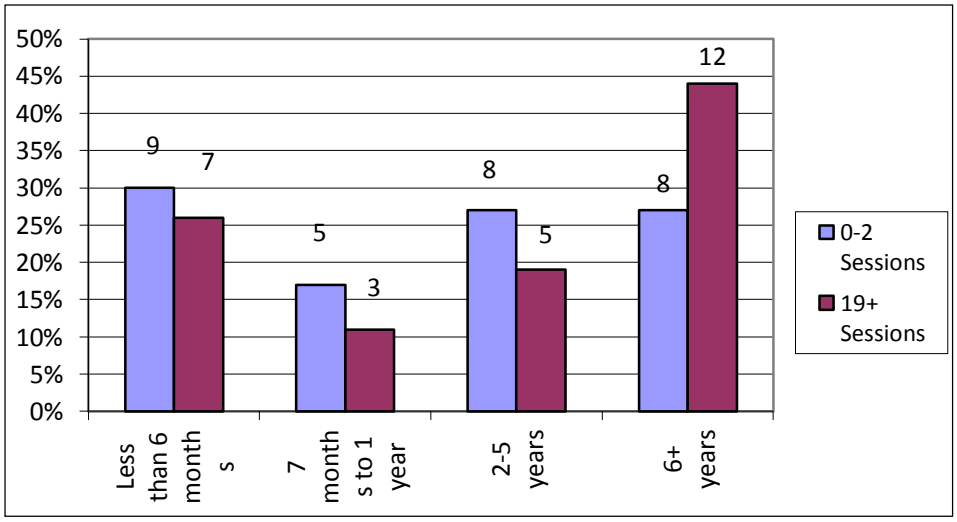

Figure 8: Comparison of time since traumatic incident for short and long term clients

Does trauma information make a difference to length of stay in counselling?

The number of types of traumas a client experiences are significantly related to how long a client stays in counselling (t=2.63; df=70, p=0.01). In other words, there is evidence to suggest that an increase in the number of different types of traumas that a client experiences will mean that the client is more likely to stay for a longer period of time.

As can see in the table below, despite the obvious differences in the proportion of clients who experience the different traumatic events, with the exception of assault, there is no link between the different types of traumatic events and how long a client stays in counselling (table below). Assault is close enough to the significance level of 0.05 to be considered statistically significant to how long a client stays in counselling, however, none of the other traumatic events are significant (Table 3).

Type of traumatic event	***Of the clients who experienced type of trauma, early leavers: N (%)***	***Of the clients who experienced type of trauma, clients who stayed for 19+ session: N (%)***	X^2	**df**	***p***
Assault	4 (33%)	8 (67%)	3.703	1	0.054
Bereavement	5 (33%)	10 (67%)	2.577	1	0.108
Rape	5 (50%)	5 (50%)	0.332	1	0.565
War	4 (40%)	6 (60%)	1.606	1	0.204
Witness to trauma	6 (43%)	8 (57%)	1.713	1	0.118

Table 3: Chi-square test: Length of counselling related to traumatic events (significant at p=0.05)

Does functioning and psychiatric conditions make a difference to length of stay in counselling?

In terms of the impact of different service providers on how long clients stay, while there are indications that Health Professionals needs to be looked at more closely, there is little indication that these different service providers and family members impact whether a client stays for a short or long period of time (Table 4).

	Valid N (0-2 Sessions)	Valid N (19+ Sessions)	Z	p-value
Authority figures	26	12	0.26693	0.79
Police	25	24	0.13000	0.897
Home affairs	23	23	1.24126	0.215
Health professionals	36	27	-1.78472	0.074
Family members	37	26	-0.54447	0.586

Table 4: Mann-Whitney U-test: Length of counselling related to different service providers (significant at p=0.05)

When looking at clients' functioning at baseline, how long a client stays is not significantly related to any of the functioning measures (Table 5):

	Valid N (0-2 Sessions)	Valid N (19+ Sessions)	Z	p-value
Solving problems	20	26	-0.13295	0.894232
Managing Daily tasks	23	24	-0.14897	0.881577
Managing Symptoms	21	25	1.69806	0.089498
Control reactions	23	24	-0.35114	0.725481
Family connections	23	24	1.33009	0.183490

Table 5: Mann-Whitney U-test: Length of counselling related to functioning indicators (significant at p=0.05)

At baseline, 24 early leavers (57%) met the cut-off for clinical levels of PTSD, while 23 clients who stayed for 19+ sessions (77%) met the cut-off for clinical levels of PTSD. In spite of this, however, the mean scores indicated through the Harvard Trauma questionnaire indicated similar scores for early leavers and clients who stayed for 19+ sessions in terms of their PTSD scores, Self-perception of functioning scores and total trauma scores (Table 6).

	Mean 0-2 Sessions (Std.Dev)	Mean 19+ Sessions (Std.Dev)	t-value	df	p
PTSD Score	2.82 (0.56)	2.79 (0.63)	0.267556	70	0.789
Self-perception of functioning score	2.70 (0.59)	2.57 (0.65)	0.861707	70	0.392
Total trauma score	2.75 (0.55)	2.66 (0.62)	0.656837	70	0.513

Table 6: T-test: Length of counselling related PTSD, Self-Perception of functioning and Trauma Scores (significant at p=0.05)

In terms of anxiety and depression, the average percentage of clients with 0-2 sessions, compared to 19 and above sessions who were considered normal, borderline or clinical at baseline assessment were relatively similar (Figures 9 & 10).

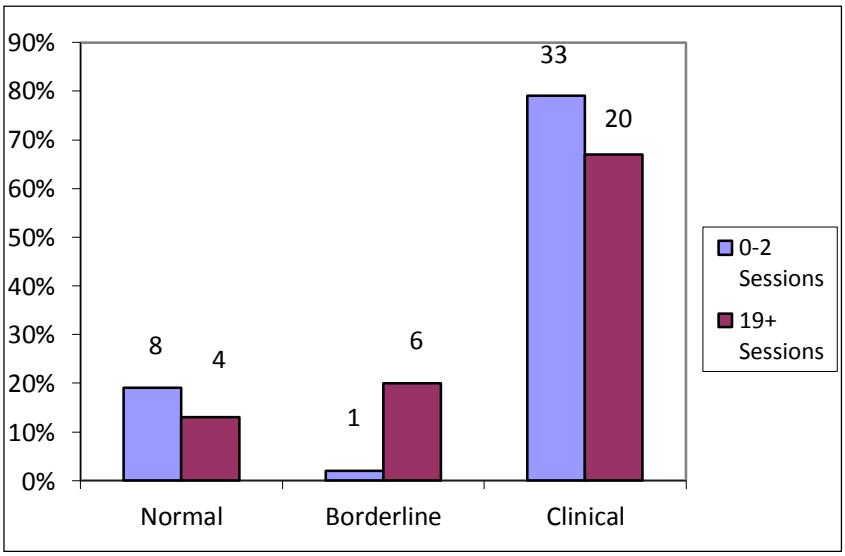

Figure 9: Comparison in Anxiety scores at baseline for clients with 0-2 Sessions and 19+ Sessions

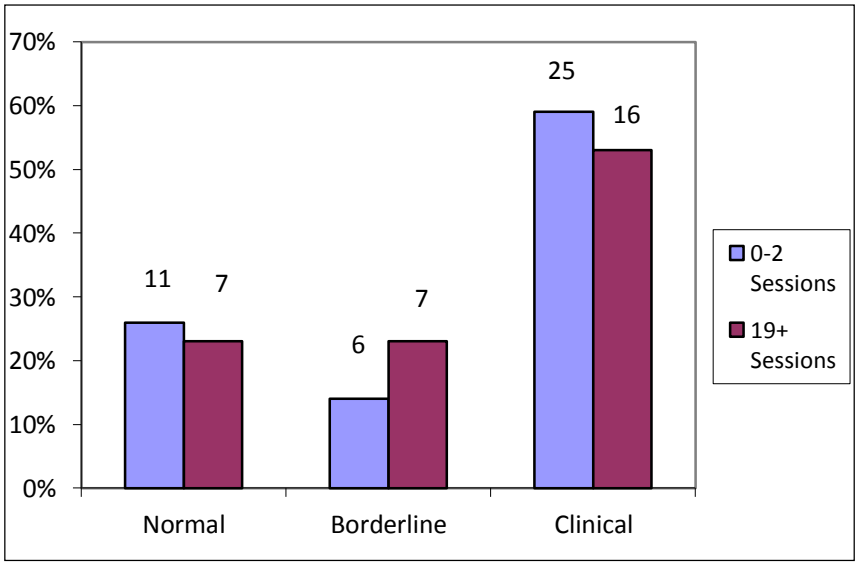

Figure 10: Comparison in Depression scores at baseline for clients with 0-2 Sessions and 19+ Sessions

At baseline, the mean anxiety and depression scores were similar for early leavers and clients who stayed for 19 sessions or more. There is no significant difference between these samples (Table 7).

	Mean 0-2 Sessions (Std.Dev)	Mean 19+ Sessions (Std.Dev)	t-value	df	p
Total Anxiety score	13.1 (5.16)	13.71 (5.72)	-0.467472	70	0.642
Total Depression score	11.47 (4.8)	11.31 (5.63)	0.124029	70	0.902

Table 7: T-test: Length of counselling related Anxiety and Depression Scores (significant at p=0.05)

Do Medical conditions and pain make a difference to length of stay in counselling?

Twenty nine of the seventy two clients included in this sample (40%) indicated that they had at least one medical condition, while 23 (32%) indicated that they suffered from pain. Our data indicates that there is no significant difference between the numbers of medical conditions of clients who stay for two or less sessions compared to those who stay for nineteen or more sessions (Table 8).

	Mean 0-2 Sessions	Mean 19+ Sessions	t-value	df	p
Total number medical conditions	1.75	1.58	0.48	29	0.63
Total number medical conditions due to torture	1.45	1.18	0.65	26	0.52
Number of types of pain	3.43	2.67	0.74	21	0.47
Number of pain due to torture	1.55	2.5	-1.07	15	0.30

Table 8: T-test: Length of counselling related number of medical conditions and pain (significant at p=0.05)

Analysis of Intervention Process Notes

There were sixteen primary areas that came out of the Intervention Process Notes. For both the clients who stayed for two or fewer sessions and those who stayed for 19 sessions or more, the area that came out with the most number of clients was “Providing specific therapeutic interventions”. This includes providing containment, psycho-education, assisting clients with problem solving, challenging irrational thoughts and providing grounding techniques. The area that had the biggest difference between these two samples was the telling of the traumatic story, with 67% of clients telling the traumatic story in the 0-2 session sample, compared to 24% of clients who told the traumatic story in the 19 sessions and above sample (Figure 11).

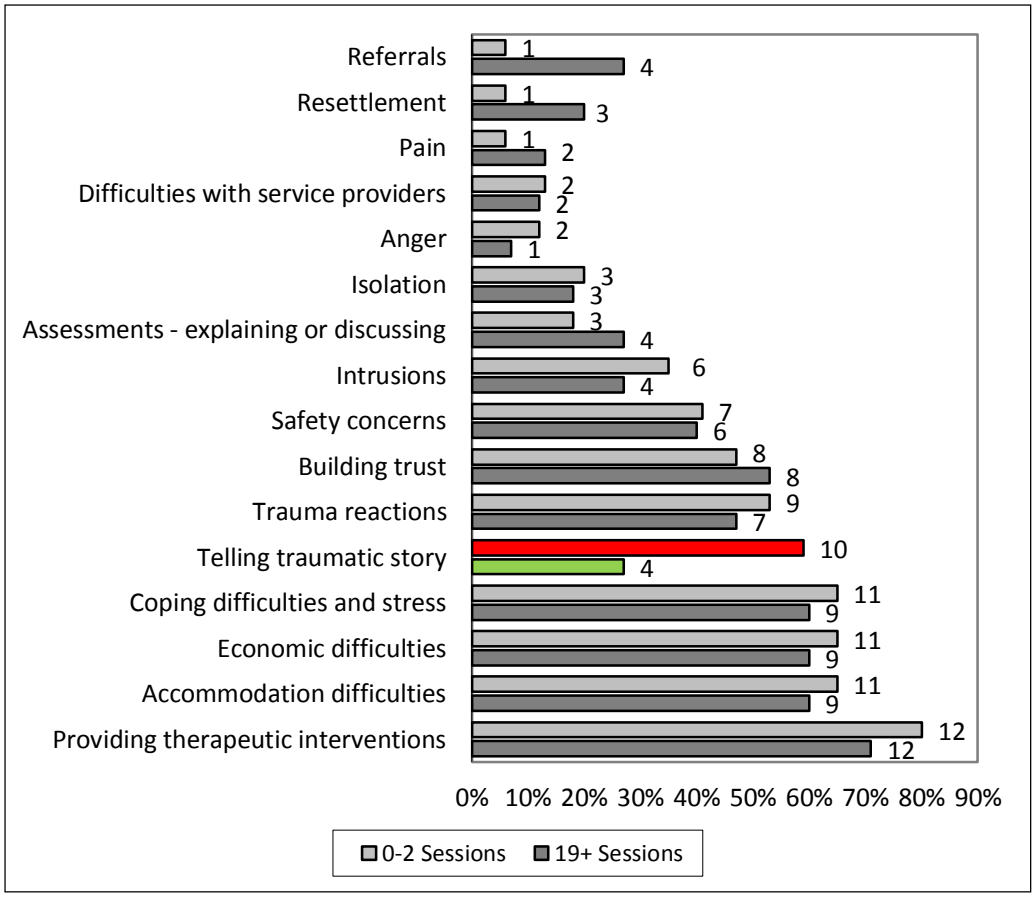

Figure 11: Comparison of what comes up in the Intervention Process Notes

The data indicates that, while there are differences between clients who stay for two sessions or less compared to those who stay for 19 sessions or more, there is no area contained within the IPNs that are significantly related to how long a client will stay in counselling. However, further discussions need to be held around the area of telling the traumatic story (X^2=3.348, df=1, p=0.0673), as well as referral of clients (X^2=2.611, df=1, p=0.106). Clients who stayed for two sessions or less appear to be more likely to tell their traumatic story, compared to those who stayed for a longer period of time. Additionally, clients who stayed for 19 sessions or more were more likely to be referred to other organisations for medical, legal, humanitarian or psychiatric assistance.

5. Discussion

The results above that there are many similarities and differences between early leavers and clients who stay for 19 sessions or more. However, there is a lot of information included that does not predict whether a client will stay for a short or long period of time (Table 9).

How long a client stays for counselling at CSVR			
	Clients who stay for two sessions or less	**Clients who stay for 19 sessions or more**	**Makes no statistical difference to how long a client stays**
The role of CSVR clinical staff	Intern, sessional worker, social work student or volunteer	Trauma professional (full time or part time	Gender of the clinician
Reasons for termination	More likely to drop out without giving a reason	More likely to terminate counselling because they found a job or moved somewhere	
Client demographics	More likely to be married	More likely to be separated, divorced, widowed or never married	Most demographic information including: • Age • Gender • Region of nationality • Legal status • Employment status • Change in employment
	More likely to have a secondary school education	Completed primary school	
Trauma information	Fewer different types of traumatic events	Higher total number of traumatic events	Specific traumatic events such as: • Rape • War • Witness to trauma • Bereavement
		Likely to have experienced assault	
Service providers and family members	-	-	The impact of the police, home affairs, health professionals and family members
Functioning and psychiatric conditions	-	-	• All measured functioning indicators • All measured psychiatric conditions including PTSD, anxiety and depression
Medical conditions and pain	-	-	Total number of medical conditions and pain

Table 9: Breakdown of what makes a difference to how long a client stays in counselling

The following discussion is based on a focus-group discussion held with clinicians, the programme manager an M&E officer and a researcher. The focus group was facilitated by this author.

The role that CSVR clinical staff play in how long clients stay

One of the variables that does make a difference to how long a client stays in counselling is who the clinician is, and what category of professional the clinician is. CSVR does not allocate clients by random assignment; rather, the more complex cases tend to go to the more experienced clinicians, and /or clinicians who have space on their client load. While clients are more likely to stay for more than two sessions with full time staff members, there are indications that clients who are with specific full time trauma professionals are more likely to have two sessions or less of therapeutic interventions. This is a cause for concern, and has been taken up at a management level. Further discussions need to be held to ensure that this be rectified.

Focus groups discussions held include the level of experience that is needed to provide therapeutic services to victims of torture. Because torture is so complex, and it affects the physical, emotional, psychological, spiritual and familial aspects of the client (Quiroga & Jaransan, 2005), as well as the broader community, more experience is needed to deal with the complex interrelationship of these areas. For this reason, clients may feel more comfortable to stay with clinicians who are able to provide all of these different areas of support. Concern comes in, however, when clients rely so heavily on the support of the clinician that they do not terminate counselling (thus staying for 19 sessions or more for the support of the clinician). Ensuring that clients are empowered and feel capable to interrelate to others and /or gain social support is important in ensuring that they do not stay purely for the support provided by the clinician.

The gender of the clinician makes no statistical difference to how long a client stays in counselling, indicating that clients will not stay for a shorter or longer period of time depending on whether their clinician is male or female.

Almost half of the clients who are assigned to non-permanent members of staff[7] (48%) dropped out between 0-2 sessions. While this may speak to the temporary nature of the work of these therapists, it also raises questions about whether full and part-time trauma professional staff are available enough for discussion and mentorship. It further raises questions whether transfer of cases within the clinic once a non-permanent staff member is due to leave is appropriate or useful and whether it is working. Clients may be transferred to other CSVR staff members, but these may "fall through the cracks" because of high client loads or clients not being followed up on correctly. Additionally, the non-permanent staff members may not follow up on cases that they have referred because of changing priorities as they leave CSVR. These areas indicate the need for closer case management and supervision.

[7] Non-permanent members of staff include "Sessional Workers", i.e., contract staff who only come into CSVR to have sessions with clients and document their work; volunteers, Masters of Clinical Psychology Interns; Masters of Counselling Psychology Interns; and Social Work Students

The focus group discussions held further looked at how important the training and experience that is offered within CSVR is to the ongoing work of the clinical team. Full time staff is more likely to be included in meetings, discussions and training sessions. These expose the staff members to knowledge and discussions that may assist them with their clinical work. These learning and reflective spaces within CSVR are either not available or less available to part-time, temporary or consultant staff members. This is likely to impact the clients because this reflective space holds a lot of value in ensuring that the best services are provided to clients. Additionally, different modes of therapy that might be useful in different circumstances are discussed at such meetings. This indicates that access to people with knowledge, and /or inclusion of all staff members (including non-permanent staff members) in reflective spaces need to be offered to all clinical staff, rather than the full time and part time trauma professionals only.

Furthermore, full time staff members are more likely to spend every working day in the clinic, allowing for more flexibility in their schedules. This allows for more accommodation for clients who may have schedule clashes due to employment needs and/or the transient nature of being a refugee in South Africa.

These are all areas that need to be followed up on and discussions by the team will continue. Additionally, this leads to performance and management discussions which will continue.

Reasons for termination

A client is more likely to drop out and not provide a reason or stop coming for counselling without providing a reason if s/he has had two sessions or less. This appears to be an indication that such clients are not getting what they need rather than that they have recovered. Another aspect to this is that early leavers may drop out quickly if they are not getting what they want from the therapeutic relationship, and the trust that is typically built through the therapeutic relationship has not yet been built.

The reason for termination for early leavers compares to clients who have 19 sessions or more who are more likely to terminate counselling because of finding a job or moving. This may talk to the resilience factors and empowerment that happens in the therapeutic relationship whereby the client feels more able to find a job or move because his/her internal resources are built up enough for this.

Demographic information

The focus group discussions revolved around what the reasons are that a client comes in for counselling, and whether they know what our "core business"[8] (Bandeira et.al, 2013) is. Questions are raised as to whether there is a division between clients who drop out quickly because CSVR is unable to attend to their non-counselling needs and those who stay in counselling for a long period of time in the (justified or unjustified) hopes that CSVR will be able to attend to needs that are not related to counselling. It also indicates that refugees do not need more support than citizens. The implications of this is that it is essential to be specific in the screening interview as to what assistance CSVR can provide, and what the client will be referred to for assistance from other organisations.

Additionally, as may be seen from the discussion about CSVR staff members above, it may be that the quality of counselling and the characteristics of the counsellor may make more difference to how long a client stays than the protective / risk factors inherent to the client.

The two aspects of clients' demographic information that is significantly related to how long a client stays in counselling are: marital status and educational level ($p=0.0038$ and $p=0.0156$ respectively). Regarding marital status, the data indicate that unmarried, separated, divorced or widowed clients will tend to stay in counselling for 19 sessions or more, while married clients will likely stay for two sessions or less. If one considers marital status as an indication of social support, this correlates to the literature which indicates that increased social support and higher education are protective factors against traumatic symptoms (Arnetz et.al., 2013; Silove et. al., 2010; Silove et.al., 1997; Maercker et.al., 2013). Moreover, this seems to suggest that having an adult family member or a partner is a protective factor against traumatic symptoms.

On the other hand, clients who are separated, divorced, widowed or never married are more likely to stay in counselling for 19 sessions or more. This may indicate that clients who fit such a demographic are more likely to become dependent on the counsellor as his/her key support system. There may be issues of transference that are indicated in this demographic whereby if a client does not have a significant other, s/he may use the clinician as a "surrogate significant other".

[8] The "core business" of CSVR includes the provision of "psychosocial rehabilitation/therapy/counselling to victims of torture and CIDT who are in need of, willing, able, ready, and interested in engaging in the counselling processes. This could be done with individuals, couples, families and/or groups". It does not include the provision of legal, medical, and humanitarian services. For these needs a counsellor may, refer clients to other organisations who are able to assist these clients; empower clients in order to have them meet these needs and so forth (Bandeira et.al, 2013, p.12). For more information, please see Bandeira et.al, 2013)

Additionally, a client may be more vulnerable to abuse and revictimisation because s/he is isolated and does not have the support of family or the community to assist to protect him/her.

This area indicates how important social support is for the client, and how important it is to focus on social support within the therapeutic relationship. The therapist needs to ensure that the client is able to widen his/her circle of trust and support. Social skills and life skills need to be emphasised within the therapeutic space in order to assist the client and to prevent revictimisation.

Other demographic information such as how many children a client has and who the client is living with (for example, alone, in a shelter, with family, with a partner or spouse, or with strangers) does not make a difference to how long the client stays in counselling for. This may talk to the stress of having left loved ones behind in the country of origin when fleeing, as well as the stress of living in continuously traumatic environments such as South Africa. Leaving family members behind when fleeing countries is likely to be a cause for concern no matter how long the client stays in counselling. Similarly, many clients stay in difficult and potentially unsafe environments, and this may not change over the course of counselling. However, this is an area of concern for counsellors and has been mentioned as a theme that CSVR clinicians deal with often in their counselling with tortured clients (Bandeira, 2013).

Regarding educational level, clients who have had a primary school education or lower are likely to stay for 19 sessions or longer, while clients who have higher educational levels will likely stay for two sessions or less. This correlates with literature which indicates that education is related to resilience factors, and indicates that clients who have higher education will not need as much support as those who have lower educational levels.

However, areas such as gender, age, age at time of trauma, region of nationality, employment status and change in employment all do not make a difference as to how long a client will stay in counselling for. This is contradictory to what is mentioned in the literature about protective factors against traumatisation. Additionally, the legal status of the client does not make a difference to how long a client stays in counselling for.

Our data indicate that, while gender has been shown to be associated with traumatisation (i.e., women are seen to have more psychiatric symptoms such as PTSD, anxiety and depression) (Arnetz et.al., 2013; Silove et. al., 2010; Silove et.al., 1997), gender did not make a difference to how long a client stayed in counselling. In addition, neither the age indicated at baseline, nor the age at time of trauma[9], indicates how long a client will stay in

[9] As mentioned previously, age at time of trauma was not specifically asked during the screening or baseline assessment. Thus these numbers were worked out using the categorical scale of how long it had been since a client came in for counselling. Because this is given as a continuous scale rather than dates, average time was used. For this reason, further research into this information should be done before absolute conclusions can be drawn.

counselling. This questions whether the importance of who the counsellor is, and how much social support the client has (especially support from an adult partner), is more important in the length of stay for that client than other factors, especially in situations of safety concerns that are inherent in South Africa.

Trauma information

As mentioned above, the literature indicates that traumas such as rape are a risk factor for traumatic symptoms (Shalev et al, 1996; Brewin et al, 2000). We included other traumatic experiences such as bereavement (including traumatic bereavement), witness to trauma and war in such traumas. However, contrary to what was expected, the types of traumatic events that a client faced did not make a difference to how long s/he stayed in counselling. Assault gave the most significant results at $p=0.056$, however, the other traumatic events such as rape, war, bereavement (including traumatic bereavement) and witness to trauma did not alter how long a client would stay in counselling. This may indicate that clients who experience more severe traumatic events do not necessarily need more support than clients who experience less severe traumatic events.

On the other hand, this may feed into a larger picture of shame and humiliation regarding speaking about traumatic events, especially in the beginning of the therapeutic relationship when trust is still being built. Clients may not speak about their rape, war or bereavement events in the screening because they do not feel comfortable to speak about them, and may feel ashamed or guilty over the events. The discussions about assault may be easier to discuss because there may be less emotional "baggage" that is related to being assaulted, whereas other aspects of a clients traumatic experiences may be too painful to talk about, especially within the first two sessions.

Additionally, it is problematic to make decisions as to the "severity" of a trauma based on a brief description of the event given by the client in the screening process. For various reasons, clients may not discuss the full trauma and/or will downplay or exaggerate traumas during this screening process. In order to fully justify the discussion about whether certain traumatic events are "severe" or not, detailed qualitative work is needed, and this needs to include the subjectivity in different contexts.

However, the more traumatic events that a client faced, the longer s/he would likely stay in counselling. This relates to the literature which indicates that increased numbers of traumatic experiences increases a client's vulnerability factors (Hirini et.al, 2005). Clients who have more different types of traumatic events will likely need more support than those who experience fewer traumatic events.

Environmental factors

None of these service providers focused on (including authority figures, the police, home affairs and health professionals), or family members, makes a difference to how long a client stays in counselling. This indicates that how a client feels that service providers and family members impact them at baseline does not make a difference to how long a client stays in counselling or how much support they feel that they need. This may question whether these questions are adequately capturing what we would like them to capture, and whether they are capturing the essence of clients' lived experiences. These questions have been removed from the assessment tool because of the concerns about their reliability in our centre.

Functioning and Psychiatric conditions

Regarding the functioning of clients, the data indicate that there is no significant difference between the clients who stay for 0-2 sessions compared to those who stay for 19 sessions or more. This indicates that how the clients view their functioning at baseline does not make a difference to what kind of support they are looking for from CSVR and its staff.

When looking at clients' psychiatric conditions, the data indicate that none of our measured psychiatric conditions (Posttraumatic stress disorder, self-perception of functioning, and total trauma – measured using the Harvard Trauma Questionnaire, anxiety or depression – measured using the Hospital Anxiety and Depression Scale) made any significant difference to how long a client stayed in counselling for.

It is important to note that the sample that is being observed is a clinical sample of torture survivors. High levels of PTSD, anxiety and depression, as well as low functioning were observed with almost all of the clients no matter how many sessions they had. For this reason, while these are areas that need to be followed up with in terms of the impact of the work done (looking at comparing clients psychiatric and functioning indicators over time), it does not impact on how long a client stays in counselling.

Questions as to whether the assessment tool and screening process allows the client to feel confident in the therapeutic process are raised at this point: Do [early leaver] clients "fake" high scores because they do not feel that we will accept them as clients? Do clients feel confident that they will become clients no matter what their responses at baseline? What can we do to ensure that clients feel comfortable in the therapeutic process? One area that has been indicated that will assist clients to feel like they are part of the therapeutic process is the therapeutic consent form: CSVR ensures that clients consent to the research and M&E process, but no therapeutic consent form is given to, or signed by, the client.

During the focus group discussion, the clinicians brought up the notion that major psychiatric disorders and personality disorders are areas that are likely to impact clients, the

support that they need and how they engage with the therapeutic process. These are not included in the screening or assessment tool, and so further research into this area is needed. This also questions whether the assessment measures for clients who do show indications of such psychiatric disorders are focused enough to pick this up at the screening and baseline assessment phase.

Medical conditions and pain

As mentioned above, pain and medical conditions are areas of concerns for our clients. These are clients who have been emotionally, psychologically or physically tortured and pain and medical conditions are likely to play a role in their functioning. However, in spite of this, pain made no statistical difference to how long a client stayed in counselling. This may be because pain and medical conditions, like psychiatric conditions and functioning (above) are very high for most clients who come in to CSVR for services. For this reason it does not impact how long a client stays in counselling.

What the Intervention Process Notes indicate

As mentioned in the results (above), there is no area within the IPNs that is significantly related to how long a client stays in counselling. However, the two areas that were closest to significance was regarding the telling of the traumatic story, (X^2=3.348, df=1, p=0.0673), as well as referral of clients (X^2=2.611, df=1, p=0.106). Clients who stayed for two sessions or less appear to be more likely to tell their traumatic story, compared to those who stayed for a longer period of time. Additionally, clients who stayed for 19 sessions or more were more likely to be referred to other organisations for medical, legal, humanitarian or psychiatric assistance.

This suggests that clients who stay for a shorter period of time may feel re-traumatised by their experiences of re-telling the traumatic story and, even though containment likely to be provided in the therapeutic session, they may not feel ready to continue with the counselling sessions. Within the CSVR psychosocial model (Bandeira et al, 2013), it is suggested that there are traumatic reactions that occur and need to be dealt with even before going into the traumatic story. These include:

- Psycho-education
- Preparing the client for trauma exposure
- Symptom management and skills development
- Meaning making
- Trauma exposure (going through the story)

It is possible that the preliminary parts of the re-telling of the story, including the preparation, symptom management and meaning-making have not been properly dealt with, within the first two sessions, which means that the client may feel uncontained and so not want to come back to the counselling space.

Additionally, as mentioned above, clients who are referred, or where referral is discussed within the first two sessions of therapy are more likely to stay for a longer period of time. One possible reason for this, is that a client who is referred feels that their primary needs are being met and can continue with the "core business" of CSVR, namely, therapeutic interventions. They may feel more heard by the counsellor and so less frustrated if there are indications that the counsellor is not assisting them with referrals.

6. Conclusion

This report attempts to understand what the difference is between early leavers (clients who stay for 2 sessions or less) and those who stay for a longer period of time. In order to ensure that early leavers are better able to engage in the therapeutic process, we attempt to understand what is specific to this group so that we can provide better and/or more engaging services to these clients. Additionally, we attempt to understand the clients who stay in counselling for 19 sessions or more so that we can ensure that they are able to use our services, but are not over reliant on these services.

This report uses three different modes to understand these two groups: the first is an analysis of the information contained in the baseline assessments and screening interviews to understand the statistical significance between these two groups. The second is to conduct a thematic analyse of the individual intervention process notes of these two groups to look at the similarities and differences between these groups. The last is a focus group discussion facilitated by this researcher and including three clinicians, the programme manager, a researcher and an M&E officer to delve into the possible reasons for the results observed.

The report indicates that there are a number of similarities and differences between clients who stay for a short period of time, compared to those who stay for a longer period of time. While it is difficult to predict what the differences are, there are a number of areas that make a difference to how long a client stays. These include:

- Who the client's clinician is and the category of professional of the clinician
- Marital status (married clients are likely be early leavers)
- Education (clients with a secondary school education or higher will likely stay for 19 sessions or more)
- Number of traumatic events (higher number of traumatic events will likely lead to the client staying longer in counselling)
- Assault as a traumatic event (clients who experience assault are more likely to stay longer in counselling)

Interestingly, most demographic information, traumatic experiences, forms of torture, measured functioning indicators, measured psychiatric conditions and medical conditions and pain do not make a difference to how long a client stays in counselling.

The implications are that who the clinician, what his/her characteristics are and the quality of counselling, as well as a client's social support seem to make more difference to how long a client stays in counselling than the widely acknowledged resilience and protective factors.

In order to further our understanding about the clients who drop out with 0-2 sessions and those who drop out with 19 or more sessions, a thematic analysis of the first two sessions of the Intervention Process Notes was completed. This analysis indicates that, while there are no statistically significant areas that are coming out of the process notes that may indicate whether there is anything happening within the first two sessions of therapy that may impact a clients' decision to stay in counselling for a longer or shorter period of time, the two areas that need further discussions and observation are:

- The telling of the traumatic story (clients are more likely to drop out within 0-2 sessions if they have told their traumatic story)
- Referring clients or discussing referrals with them (clients are more likely to stay for 19 sessions or more if they have been referred or if referrals have been discussed with them)

Both of these have implications for the model development strategies to be implemented in 2014.

This report indicates that it is imperative to ensure similar reflective processes to all clinicians, no matter what their level of experience or role in the clinic is (such as interns, sessional workers, volunteers, full and part time trauma professionals. This will assist to ensure that there is sharing of knowledge and access to information by all staff members. It also ensures that referral systems are working and clients do not "fall between the cracks" if the counsellor terminates, but the client would like further assistance.

Additionally, the building of social support systems and the empowerment of clients is essential in ensuring that clients are supported and that clinicians do not become the primary support of the client. This needs to be focused on in the therapeutic process.

When retelling the traumatic story, there is a process of containment, preparation and psycho-education that is essential before the traumatic story is told. This ensures that the client feels supported and ready before the traumatic story is disclosed. Clients without this support are more likely to drop out quickly. Additionally, it is important to refer clients to ensure that their basic needs are met so that they are fully able to engage with the therapeutic process.

This report is an important display of what information can be obtained from an M&E system developed for therapeutic work. The information produced can be used not only to influence an individual case but to influence clinical systems and procedures and contribute to model development. By learning more about who we see, for how long, and what the differences between these two are, we can improve how and what we do.

7. Further research:

- Given the findings of this research, and its findings, it would be useful to complete an additional analysis that compares the two extreme groups (clients who stay for two sessions or less and those who stay for 19 sessions or more), however this should be done analysed by comparing:
  - Clients who stay for two sessions or less compared to clients with three or more sessions
  - Clients who stay for 19 sessions or more compared to clients with 0-18 sessions.

  This will assist to further understand these two groups. Comparing them to the full sample will allow for a deeper understanding of their characteristics and how to better assist them

- Further understandings of the clinicians are needed. This includes how long the clinician has been conducting counselling, and whether this impacts how long a client stays in counselling

- An analysis of clients who experience psychiatric features (such as major psychiatric disorders and personality disorders) that are not included in our baseline assessment should be conducted in order to understand what the impact is of these disorders on the client and what the impact is of these disorders on the therapeutic process

8. References

Ahern, J. & Galea, S. (2006) Social context and depression after a disaster: the role of income inequality: *Journal of Epidemiology and Community Health* 60 (9) pp.766-770

Arnetz, J., Rofa, Y., Arnetz, B., Ventimiglia, M., Jamil, H. (2013) Resilience as a Protective Factor Against the Development of Psychopathology Among Refugees: *The Journal of Nervous and Mental Disease,* 201 (3) pp. 167-172

Bandeira, M (2013) *Developing an African Torture Rehabilitation Model: A contextually-informed, evidence-based psychosocial model for the rehabilitation of victims of torture. Part 1: Setting the foundations of an African Torture Rehabilitation Model through research.* Unpublished report by the Centre for the Study of Violence and Reconciliation

Bandeira, M., Garcia, M., Kekana, B., Naicker, P., Uweziye, G., Smith, E & Laveta, V., (2013) *Developing an African Torture Rehabilitation Model: A contextually-informed, evidence-based psychosocial model for the rehabilitation of victims of torture*. *Part 2: Detailing an African Torture Rehabilitation Model through engagement with the clinical team.* Unpublished report by the Centre for the Study of Violence and Reconciliation

Bandeira, M., Higson-Smith, C., Bantjes, M. & Polatin, P (2010) The land of Milk and Honey: A picture of refugee torture survivors presenting for treatment in a South African trauma centre. *Torture* 20 (2) pp 92-103

Bantjes, M & Langa, M (2011) *Finding our way: developing a community work model for addressing torture.* Unpublished report by the CSVR

Blair, R.G. (2000) Risk factors associated with PTSD and major depression among Cambodian refugees in Utah: *Health and Social Work* 25 (1) pp.23-30

Brewin, C.R., Andrews, B., & Valentine, J.D. (2000) Meta-Analysis of Risk Factors for Posttraumatic Stress Disorder in Trauma-Exposed Adults: *Journal of Consulting and Clinical Psychology* 68 (5) pp. 748-766

Dix-Peek, D. (2011) *Profiling Torture II: Addressing Torture and its consequences in South Africa. Monitoring and Evaluation Progress Report to end December 2011.* Unpublished report by the CSVR http://www.csvr.org.za/docs/ProfilingTortureIIMandEbooklet2009-2011.pdf

Elklit, A., Østergård Kjær, K, Lasgaard, M. & Palic, S. (2012) Social support, coping and posttraumatic stress symptoms in young refugees: *Torture*, 22 (1) pp.11-23

Higson-Smith, C. (2013) Counselling torture survivors in contexts of ongoing threat: Narratives from Sub-Saharan Africa: *Peace and Conflict: Journal of Peace Psychology* 9(2) pp.164-179

Higson-Smith, C., Mulder, B., Masitha, S. (2007) *Human Dignity Has No Nationality: A situational analysis of the health needs of exiled torture survivors living in Johannesburg, South Africa.* Unpublished report by the CSVR

Hirini, P., Ftett, R., Long, N., Mitlar, M. (2005) Frequency of Traumatic Events, Physical and Psychological Health among Maori. *New Zealand Journal of Psychology* 34 (1) pp. 20-27

Hooberman, J., Rosenfeld, B., Rasmussen, A & Keller, A. (2010) Resilience in Trauma-Exposed Refugees: The Moderating Effect of Coping Style on Resilience Variables. *American Journal of Orthopsychiatry* 30 (4) pp. 557-563

Maercker, A., Gäbler, I., O'Niel, J, Schützwohl, M., Müller, M. (2013), Long-term trajectories of PTSD or resilience in former East German Political prisoners: *Torture*, 23(1), pp. 15-27

Miller, K.E., & Rasmussen A. (2010) War exposure, daily stressors, and mental health in conflict and post-conflict settings: Bridging the divide between trauma-focused and psychosocial frameworks: *Social Science and Medicine:* 70 pp.7-16

Mollica, R.F., MacDonald, L.S., Massagli, M.P., & Silove, D.M. (1994) "Measuring Trauma, Measuring Torture: Instructions and guidance on the utilization of the Harvard Program in Refugee Trauma's Versions of The Hopkins Symptom Checklist-25 (HSCL-25) & The Harvard Trauma Questionnaire (HTQ)". Cambridge, MA: Harvard Programme in Refugee Trauma

Montgomery, E. (2010) Trauma and resilience in young refugees: A 9-year follow-up study. *Development and Psychopathology,* 22 (2) pp. 477-489

Quiroga, J. & Jaranson, J.M. (2005) Politically motivated torture and its survivors: A desk study review of the literature. *Torture* 16 (2-3) pp. 1-112

Silove, D., Brooks, R., Steel Bateman, C., Steel, Z., Fonseca, Z., Amaral, C., Rodger, J., & Soosay, I (2010) Social and Trauma-Related Pathways Leading to Psychological Distress and Functional Limitations Four Years After the Humanitarian Emergency of Timor-Leste: *Journal of Traumatic Stress,* 23 (1) pp. 151-160

Silove, D., Sinnerbrink, I., Field, A., Manicavasagar, V., & Steel, Z (1997) Anxiety, depression and PTSD in asylum seekers: associations with pre-migratory trauma and post-migration stressors: *British Journal of Psychiatry.* 170 pp.351-357

United Nations (1984) *Convention against torture and other cruel, inhuman or degrading treatment or punishment.* Retrieved from the World Wide Web www2.ohchr.org/English/law/cat.htm on 06/12/2011

World Health Organisation (2001) *International Classification of Functioning, Disability and Health*: World Health Organisation http://www.disabilitaincifre.it/documenti/ICF_18.pdf

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