CSVR
The Centre for the Study of Violence and Reconciliation

GENDER AND TORTURE
DOES IT MATTER?

An exploration of the ways in which gender influences the impact of torture and rehabilitation services

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1. INTRODUCTION

This report forms part of a larger project which aimed at developing an African Torture Rehabilitation Model: a contextually-informed, evidence-based psychosocial model for the rehabilitation of victims of torture. That process is outlined in two reports which are available on the CSVR website (www.csvr.org.za). When developing the above-mentioned project it became clear that it presented an opportunity to explore gender aspects of torture and its consequences.

There is a gap in the literature in terms of gender and torture, something that is both necessary and important to the field, especially to clinicians working with victims of torture. Given the limited research available, it was decided to explore this as part of the larger project. This report outlines the results from the gender-focussed questions included in the research process. It provides an interesting exploration of the ways in which gender influences both the experience of torture and its impact.

By reviewing the literature available, looking at the analysis of 514 individual session process notes of counselling sessions held with victims of torture, and using a consensus building process with several experienced people in the field, this reports offers important and interesting information into the ways in which gender plays a role in the way in which torture is experienced and rehabilitation therefrom.

2. LITERATURE REVIEW

As the first stage of this research project, a review of the existing literature on the impact of torture and torture rehabilitation was carried out. The review focused on existing knowledge on the impact of torture on several levels, namely: psychological, social, economic, and physical, as well as literature that focused on intervention strategies and programs that have been developed for torture survivors. The review resulted in a list of 80 articles written in English with preference given to those published more recently.

The findings from the review of the relevant literature indicate that gender has not been rigorously or systematically investigated in relation to the impact of torture, or subsequent rehabilitation strategies. Importantly, while the majority of research around torture rehabilitation has used mixed-gender samples, very few projects have disaggregated their data according to gender, and few have made specific mention to differences in impact or recovery according to gender. Quiroga and Jaranson (2005)[1] in their own desk study of the available literature on torture rehabilitation similarly noted that various [other] reviews have indicated that many studies of torture survivors have failed to report how factors such as gender and cultural traits (among others) relate to post-torture symptoms, and stressed that studies exploring the effects of trauma and gender on mental and physical health are needed.

The gender discourse that exists within the literature base primarily focuses on proposed gender differences around the following three themes: 1) susceptibility/vulnerability to torture victimization; 2) the prevalence and impact of sexual torture/violence; 3) susceptibility/vulnerability to developing/reporting psychiatric illnesses/disorders following a torture experience, and relatedly, positive and negative coping strategies following a torture experience.

One of the few torture rehabilitation studies that included an explicit discussion around gender differences was that by Pabilonia et al (2010)[2]. The study presents a position on each of the gender themes listed above, which provides an opportunity to critically evaluate the consensus in the literature base around each theme. They argue that men and women are equally likely to experience torture; that women are particularly at risk of organised and gender-based violence, including rape; and finally, that women are more likely to have more negative reactions, ineffective coping mechanisms, and difficulties in adapting after torture.

Theme One

Likelihood of Torture Victimization

The first assertion made by Pabilonia et al (2010) that, "[w]omen are just as likely as men to experience torture…" reflects a position around the theme of the likelihood of torture victimization. In this case, the claim made by Pabilonia et al (2010) is informed by a study conducted by Jaranson et al (2004)[3], which found that in a community sample of 1, 134 East Africans living in Minnesota, women were tortured as often as men. This data importantly produced evidence contrary to the long-standing assumption in the field that women are less likely than men to experience torture.[4 5 6] For instance, Jaranson et al (2004) explained, that historically, torture rehabilitation centres have claimed that male leaders of communities (who were often more educated) were targeted to serve as an example for the community. Robertson et al. (2006) have similarly noted that torture has been used against intellectuals, activists, and community leaders, who are largely men[7].

While the latter position has long existed as an underlying assumption in the literature, findings from empirical studies have often supported such a claim. For instance, a study by Hooberman et al. (2007), which sought to classify the torture experience of refugees living in the United States, found that men experienced significantly more traumas in beating and deprivation factors, while women experienced significantly more traumas than men in the family torture category, highlighting that males are more likely to suffer direct torture victimization, while females are more likely to suffer indirect victimization. Additionally, Higson-Smith et al (2010) in their study found that men experienced higher levels of traumatic events and were more likely to have experienced torture[8].

However, the findings mentioned above suggest that this longstanding assumption may require further exploration. The issue of likelihood of victimisation may be influenced by specific contextual factors. In addition, gender may be a factor in the methods of torture used, with certain gendered forms of torture not being reported on/considered in these studies.

Indeed, the changing nature of warfare may provide good reason to challenge certain assumptions about the prevalence of torture, specifically amongst females. The female experience of armed conflict has in the last decade or so increasingly become a focus of the international human rights and humanitarian communities, particularly with the international media attention around "rape as a weapon of war." The review offered by Brown (2012)[9], illustrates the extent to which rape is being used as a weapon in the Democratic Republic of Congo. Within this context, there has been a strong call from advocates in these communities to consider rape as a method of torture. While there is also a call for rape in the domestic or private sphere to be understood as a form of torture[10], in the torture rehabilitation literature, it is primarily rape perpetrated by actors acting in an "official capacity," or in the context of political armed conflict, that is becoming understood as a form of torture[1].

However the lack of clear consensus is evident in the frequency that authors often discuss torture and rape as two separate experiences. Consensus on this issue would have implications for the way in which researchers explore the likelihood of victimisation.

Theme Two

Prevalence and Impact of Sexual Violence/Torture

It is important to note that within the body of literature on torture impact and rehabilitation, there is a dearth of information around sexual torture prevalence and impact, mostly due to the sensitive nature of the topic, and the subsequent lack of disclosure by victims (often due to the stigma that is attached to such victimization), and because there is inconsistency in the language and terms that are used to research sexual violence/torture[1]. However, there is a significant amount of literature available on sexual violence in armed conflict and displacement contexts, particularly around 'rape as a weapon of war'[7], but it is not refer red to or conceptualized explicitly as 'sexual torture'. There are over 25 empirical reports on the prevalence/magnitude of sexual violence in the DRC alone, and many reports which focus on sexual violence in the Balkans conflict, Rwanda, Sudan, Cambodia, Guatemala, Peru, etc., but importantly, such reports would not come up in searches for 'sexual torture.'

Lira and Weinstein (1986) cite Agger's definition of sexual torture as

> **"The use of any form of sexual activity with the purpose of manifesting aggression and of causing physical and psychological damage"[11].**

Quiroga and Jaranson (2005) explain that, the goal of sexual torture is to destroy individual identity and disturb sexual functioning[1]. Sexual torture is discussed in the literature as distinctly traumatic with prolonged, repeated exposure referred to as the most traumatising human experience[12].

The general consensus in the literature is that females suffer disproportionately from sexual torture, compared to their male counterparts[2]. Additionally, Drozdek and Bolwer (2011) found that rape or sexual abuse was reported by 50% of the females and by 26% of the male participants in their study[13]. Morentin et al (2008) in their study found that there was a preference of sexual torture on women[14]. Arcel (2002) has also claimed that gender-specific torture is directed disproportionately or primarily against women[15].

While the assumption that females suffer disproportionately from sexual violence is likely to be accurate, claims around a higher prevalence of sexual torture used against females are difficult to confirm, as prevalence data on sexual torture is severely limited due to underreporting on the part of victims, both male and female[16]. Furthermore, Quiroga and Jaranson (2005) note that sexual torture of men has not been systematically studied[1]. Sivakumaran (2007), one of the few authors to focus on sexual violence (including sexual torture) perpetrated against males, explained that, where sexual violence has been investigated, sexual violence against men is seen as regular and widespread, although not at the same rate as sexual violence against women[17].

Indeed, Russel (2007) discussed that, there is limited knowledge regarding the nature of male sexual violence as well as the consequences experienced by the victims. This leads to limited assistance and justice[18].

While it is important to understand the nature of female vulnerability to torture and extreme violence, the extensive focus on sexual violence against females has created a context where men and boys are overlooked by key stakeholders and service providers (humanitarian workers, international and national criminal law, rehabilitation practitioners) as possible victims of sexual torture, potentially limiting opportunities for the effective rehabilitation of male torture victims. This literature review highlighted the need to critically reflect on long-held beliefs about sexual violence, and investigate both male and female vulnerability to sexual torture and any gender differences around the impact of such torture methods.

With regard to the impact of sexual torture, certain authors make the case that sexual torture is linked to increased severity of psychiatric illness. For example, Hooberman et al. (2007) found in their study that scores on the rape/sexual assault factor were positively correlated with severity of anxiety symptoms, depressive symptoms, and PTSD symptom severity[19]. Quiroga and Jaranson (2005) note a higher frequency of PTSD following sexual assault than for other crimes.[1]

However, there is very little information in the literature with regard to gender differences around the impact of sexual torture. Gender differences that are discussed are primarily in relation to the social impact of sexual torture. For example, Patel (2010) highlighted the importance of cultural gender roles, which shape the impact of rape for any victim and the presenting traumatic symptoms. Stigmatisation and sanctions imposed on women who have been raped inevitably impact on their reaction to the rape[20].

Indeed, the stigma that female rape victims face is the gendered impact of sexual torture that is discussed most frequently. Interestingly however, Patel (2010) claims, it is often more difficult for men to disclose rape than for women. Further explaining that this may be exacerbated by their notions of masculinity, sexuality, and roles in society[20]. There is certainly not consensus on this proposed gender difference given the general dearth of research on sexual torture generally, and on male victims specifically.

Theme Three

Prevalence of Psychiatric Illnesses and Coping Strategies

Pabilonia et al. (2010) argue that:

> **"Because women torture survivors are poorly prepared for the risk of torture, they tend to have a greater amount of psychiatric problems and ineffective coping mechanisms as compared to males who have experienced similar torture" (p. 5)[2].**

This position highlights a proposed gender difference that has clear implications for rehabilitation programming; however, the consensus on this claim in the literature is not clear.

There does however appear to be consensus in the literature that females are more likely to develop PTSD than men. Leaman and Gee (2012) note that, female torture survivors are at a higher risk of PTSD and depression (Keller et al., 2006; Van Ommeren et al., 2001, Hooberman et al., 2007)"[21] and Breslau et al., (1998) found that, when exposed to the same trauma, women are four times more likely to develop PTSD than men[22]. Similiarly, Yasan et al. (2008) reported women being twice as likely to develop PTSD as men who experience the same traumatic events[23]. Suli and Como (2002) found a 59% higher PTSD prevalence rate in women[24].

Certain authors have also claimed that females are generally more symptomatic than men and exhibit poor coping skills comparatively[25]. Sachs et al. (2008) in their study on trauma and coping among Tibetan refugees arriving in India found that women were significantly more symptomatic than men[26]. Similarly, Van Ommeren et al. (2001) found that women who were tortured reported more lifetime anxiety, somatoform pain, affective, and dissociative disorders[27]. Additionally, Ekblad et al. (2002) completed a three month follow up of 131 adult Kosovars mass-displaced to Sweden and found that women had more psychiatric symptoms than men[28].

Thus while there seems to be consensus around the point that females are more likely to report with higher levels of PTSD, anxiety and depression, it is less clear whether it is accurate to say that females generally have poor or ineffective coping mechanisms. Nonetheless, gender differences around resilience in torture survivors have not been systematically explored and should become a focus of further research.

Additionally, in terms of coping mechanisms, certain authors highlight that men are more likely to resort to substance abuse than their female counterparts. For example, Basoglu et al. (1994a) found that men are more likely to have PTSD associated with substance abuse and women to have a history of depression or anxiety (Kastrup and Arcel, 2004)[29]. This substance abuse and PTSD co-morbidity appears to be gender-related, more often seen in men than women (Kastrup and Arcel, 2004)[29].

3. METHODOLOGY

Gender Analysis Framework

The following definition of 'gender,' from the UN Women guide to concepts and definitions[30] was used to guide the gender analysis throughout the Delphi process:

> **Gender refers to the social attributes and opportunities associated with being male and female and the relationships between women and men and girls and boys, as well as the relations between women and those between men. These attributes, opportunities, and relationships are socially constructed and are learned through socialization processes. They are context/time-specific and changeable. Gender determines what is expected, allowed and valued in a women or a man in a given context. In most societies there are differences and inequalities between women and men in responsibilities assigned, activities undertaken, access to and control over resources, as well as decision-making opportunities. Gender is part of the broader socio-cultural context. Other important criteria for socio-cultural analysis include race, poverty level, ethnic group and age.**

Importantly, the conceptual framework provided by this definition is grounded in the understanding that both 'culture' and 'community' shape understandings of gender in different contexts. The beliefs, habits and ideas shared within different cultures and communities are closely related to power hierarchies, which act as their justification or legitimation. Equally, cultural beliefs, habits and ideas are individuals' guide to life and, by extension, how they experience trauma. Therefore, the differences and inequalities between the roles and expectations of men and women in any given social context influence the methods by which torture is perpetrated, as well as how victims are impacted by and subsequently cope with their victimization.

The Delphi Technique

The framework described above provided conceptual guidelines throughout the gender analysis of the data. The data regarding gender was obtained through questions included in the Delphi technique used in the larger research project. Here, a panel of 18 people experienced in the field of torture was assembled. The role of the panel was to assist in building consensus on both the impact of torture and the most adequate intervention options. This was achieved by using the Delphi technique, which "is in essence a series of sequential questionnaires or 'rounds', interspersed by controlled feedback, that seek to gain the most reliable consensus of opinion of a group of experts"[31]. The technique has been adapted for use to various questions or processes[32], which means it "is well suited as a means and method for consensus-building by using a series of questionnaires to collect data from a panel of selected subjects"[33]. The technique is set up in the format of rounds, whereby the panel respond to questions independently. In between rounds, the data is analysed and feedback given to the panel. The initial round usually consists of open-ended questions but can also consist of structured questions based on literature. Subsequent rounds seek to quantify the results gathered. Through the use of ranking and rating techniques, consensus is finally built. Most often, a percentage agreement level is used for inclusion.

The Delphi technique does not specify the ideal number of participants or panellists, as this depends on factors such as the problem statement, the resources available (time and money), and the availability of experienced people in the field.

The Delphi Panel

The process sought to include a minimum of 10 panellists including a range of academics, practitioners, and researchers with experience and knowledge in this field and/or with this context/client population. Both international and local people were sought, while CSVR's own clinicians, who met the criteria, were also included on the panel. Criteria for inclusion included:

Practitioners were required to have:

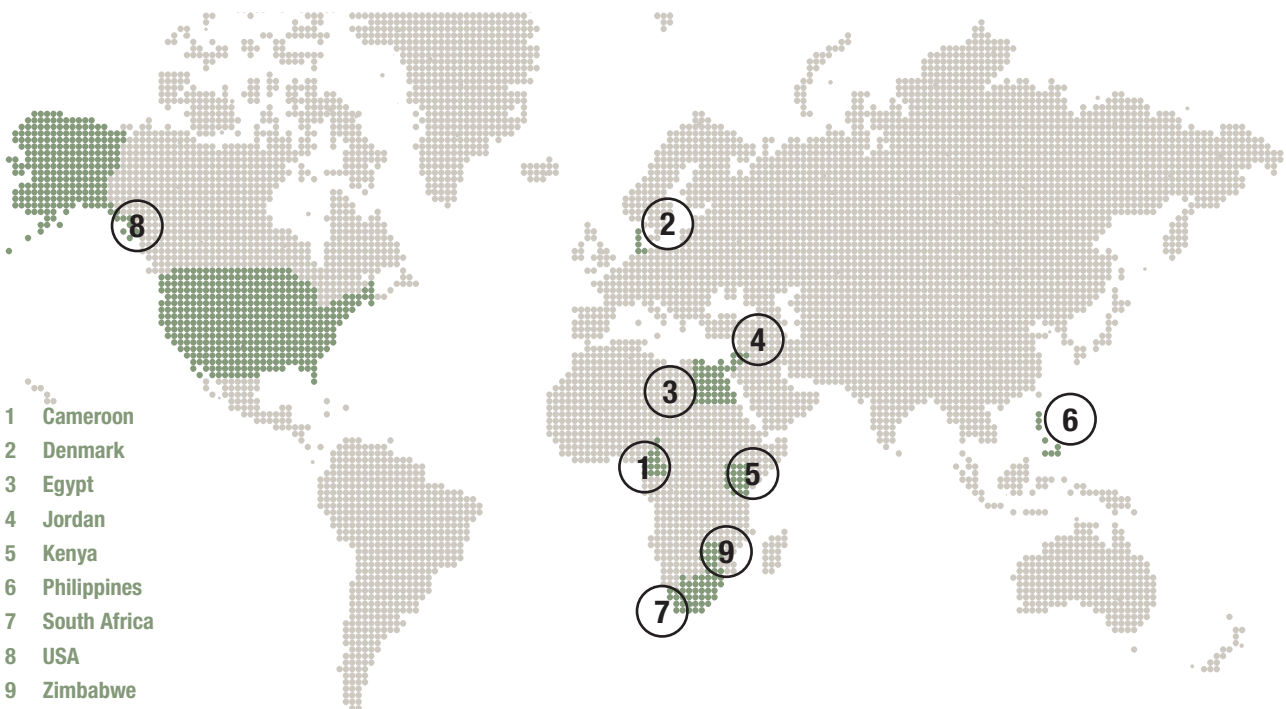
- A minimum of 5 years of experience in working with victims of torture, and/or
- Provided interventions to a minimum of 50 torture victims, and/or
- Provided supervision to a minimum of 10 clinicians providing interventions to victims of torture in the last 5 years.

Researchers/academics were required to have:

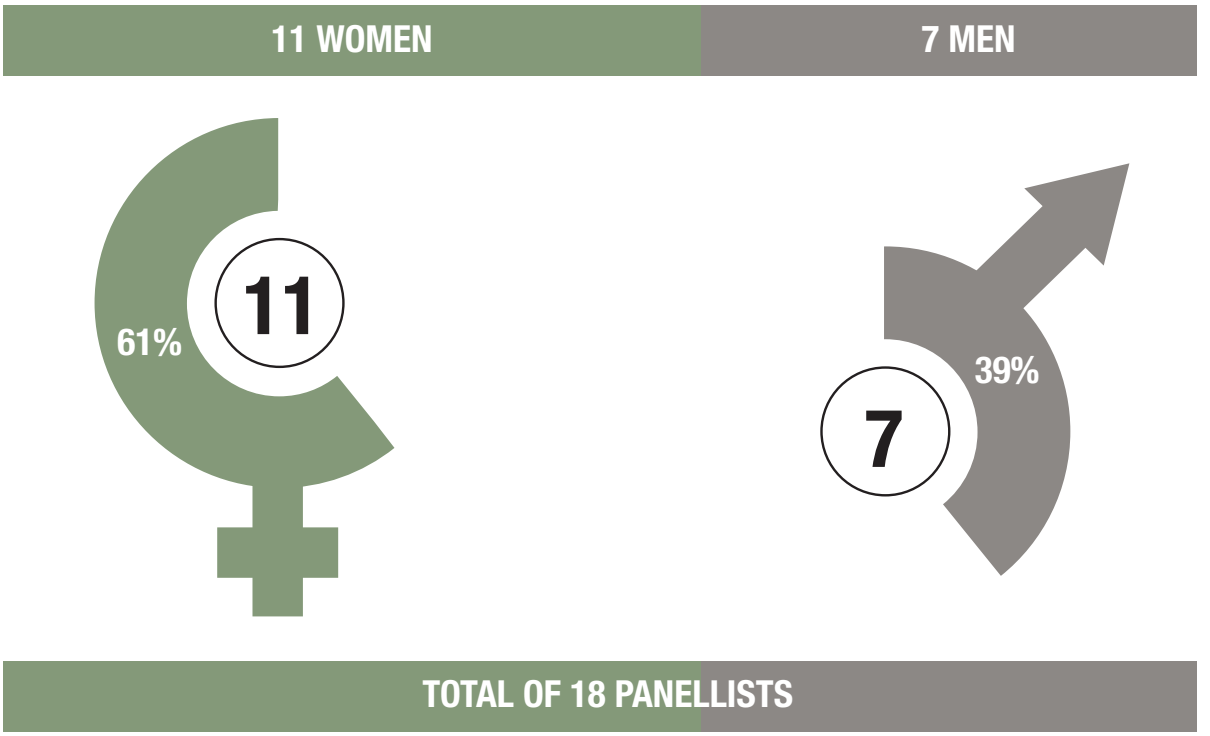
- A minimum of two publications in the last 5 years in the field of torture rehabilitation, and/or
- Provided supervision to researcher(s) exploring the topic of torture rehabilitation in the last 5 years.

The final panel consisted of 18 panellists and included

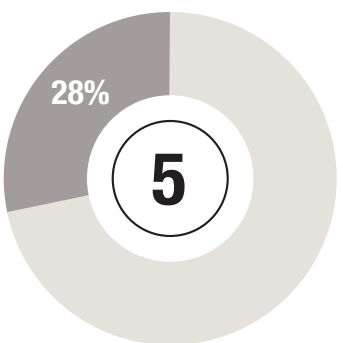
At the time of participating in the process, panellists were based in 9 different countries, namely:



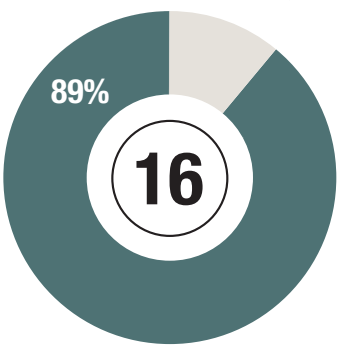
- Except for the panellists based in Jordan and Egypt (who are originally from North America), all the other panellists come from the countries they are based in.



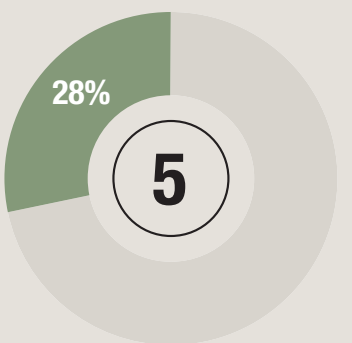
Panellists from the CSVR



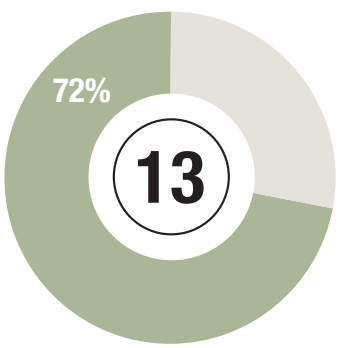
Panellists that met "Practitioners" criteria



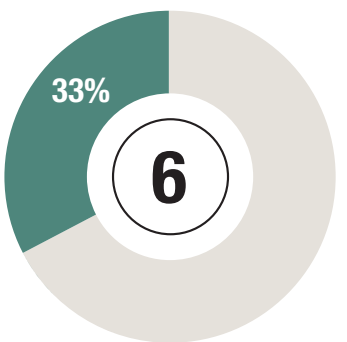
Panellists from the global north.



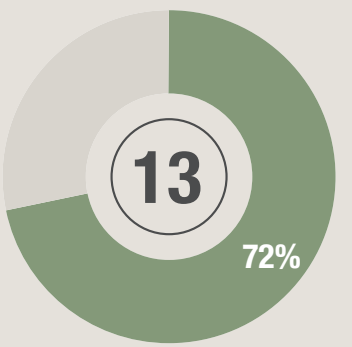
Panellists that met "Supervisors" criteria



Panellists that met "Researchers" criteria



Panellists from the global south



The Delphi Rounds

The Delphi process for this project was originally designed to include 4 rounds, which panellists responded to. A fifth round was added during the process. Only the first 3 rounds included gender-related questions. Information gathered from the literature review and the analysis of Individual Process Notes (IPNs) of sessions held with victims of torture informed some of the questions included in the Delphi technique. Below is a description of the questions asked in each round in terms of gender.

Round One asked panellists:

- **If, in their experience, men and women experience torture in different ways (open-ended question).**
- **If, in their experience, the daily stressors that follow a torture experience are felt differently by men and women (open-ended question).**

As the nature of the Delphi process is to build consensus amongst a group, it was important to start with open-ended questions so as to orient ourselves in the current knowledge of the panellists and to evaluate which issues would be the most relevant and important to build consensus around in going forward. Additionally, open-ended questions were thought to be the best way to ensure nuanced, rich responses, and are the most typical way to start off a Delphi process.

Given that the impact of torture on survivors was a significant focus of this study, the gender section in Round I focused on the degree to which gender is useful for understanding the impact of torture.

Thematic content analysis (TCA) was conducted, as it was believed that the main themes to emerge from the panellist responses would reflect the most relevant issues around gender and torture impact, which should be explored in subsequent Delphi rounds, in the context of intervention strategies. The responses document was read numerous times to break into the data, and after becoming familiar with the responses, a list of themes that emerged from the responses was drafted. Themes were organized around potential gender differences, therefore most themes are gender-specific; for example: Male: less agency re. family; or, Female: indirect victim.

The original list of themes was extensive and quite specific, and so the themes that represented more specific issues were collapsed under broader themes. Additionally, after becoming familiar with the data, it became clear that many panellists discussed issues relating to the second question in the first question and vice versa, and so the lists of themes from the two questions were merged into one list of comprehensive, condensed themes. The condensed list of themes which emerged from both responses will be presented in the following 'Results' section. The data was first coded manually with this list, and then electronically using NVivo 8.0.

Using NVivo 8.0, a 'document coding report' was produced which presented each node, or theme, with the sections of data that were coded with that node/theme. The corresponding statements for each of the themes were then summarized and condensed into one overarching statement that, to the best degree possible, represented the consensus around that issue in the responses. Where panellists focused on different aspects of the same theme, more than one statement was created to represent this.

The statements that were created were understood to reflect the most important points from Round I, and are were meant to capture possible gender differences relevant to torture impact and rehabilitation. Similar comprehensive statements were created to represent gender differences that were highlighted during the literature review, and also to represent the themes with the largest ordinal differences in the Intervention Process Notes (IPN) analysis. As part of the broader research project, a Thematic Content Analysis of 514 individual session process notes of sessions held with victims of torture was conducted to identify impacts and interventions . For this report, lists of impact and intervention themes were desegregated according to gender. Ordinal differences in themes emerging according to gender were established and those that fell within the 25% highest ordinal difference were included in the statements.

These statements were combined into a comprehensive document and were then collapsed to decrease repetition of similar points, which produced a final list of 29 statements.

Round Two asked panellists:

- **To rate their level of agreement with 29 gender-related statements that emerged from the data gathered in Round One, the INPs analysis, and literature (1- Strongly agree; 2- Agree; 3- Neither agree nor disagree; 4- Disagree; 5- Strongly disagree).**

The 29 statements that emerged from Round 1 were presented in the second round for panellists to evaluate the degree to which they agreed or disagreed with the statement using a five-point scale from strongly agree to strongly disagree, and then to assess whether this issue was relevant or significant in terms of designing an intervention.

When responses were reviewed, it became clear that a few panellists were unclear about the question of, 'whether the issue is relevant in terms of therapy.' Given this confusion, all responses from this column were not considered in the analysis. However, this error was addressed in Round III, which will be discussed below.

Therefore, the analysis of Round II was mostly quantitative, and evaluated whether panellists agreed or disagreed with each of the 29 statements, and then a TCA was conducted on the few comments that were provided by panellists.

Using Excel, a spread sheet was created which presented how many respondents either 'strongly agreed,' 'agreed,' 'disagreed,' or 'strongly disagreed,' with each statement. Next, an 'agree' column was created on the spread sheet, which was the composite of 'strongly agree' and 'agree,' as well as a 'disagree' column, which was the composite of 'strongly disagree' and 'disagree.' Then the numbers of panellist responses under each scale anchor, for each statement, were converted into percentages.

After creating the percentages it was clear which statements most panellists agreed with, those that most disagreed with, and those where panellists were split between agreeing and disagreeing. The statements that more than 80 per cent of panellists agreed with were highlighted as those statements that generated the most consensus, and were asked about in Round III, in terms of the implications of these issues for intervention. The need to keep the gender section concise contributed to the decision of an 80 per cent consensus cut off mark, rather than a lower threshold.

Lastly, the statements that generated the most non-consensus (when the group was split between agreeing and disagreeing), and the statements that most panellists disagreed with, were highlighted. The seven statements with the lowest difference values between the 'agree' and 'disagree' columns were included in Round III, as an optional section to explore why non-consensus occurred.

Finally, a table was created to organize any qualitative comments panellists gave for the statements, although not many comments were provided. These comments were useful however, when analysing the progression of the Delphi responses and considering how certain panellists' positions shifted throughout the various rounds.

Round Three asked panellists:

- **To describe aspects of interventions that should differ between male and female clients. In other words, the gender considerations that affect the nature/type of intervention used for a client.**
- **To describe any issues that clinicians should consider when working with a client of the opposite or same gender.**
- **To describe the implications for intervention for both male and female clients of the gender statements that 80% of panellists agreed with. In other words, how each of these gender differences would be addressed within the therapeutic space. 10 statements met the criteria.**
- **To comment on their position regarding 7 gender statements where there was no clear consensus among panellists, or with which panellists disagreed with the statement (optional section).**

The main purpose of Round I and II was to determine what were the most relevant and important gender differences to consider when trying to understand the experience and impact of torture, if any. Round III of the Delphi gender section sought to move away from exploring impact, and towards investigating how intervention can be improved, or made more effective, to better address these potential gender differences.

These questions were analysed separately as the questions were conceptually distinct, as were the responses. All answers for the first question were collected within a document, and TCA was conducted, which generated a list of themes that came up in the responses, which was further collapsed into a more concise list of themes, similar to the process outlined for the analysis of the Round I responses. The same was done for the second question. After consideration and discussion around the final list of themes generated from each of these questions, it was decided that it was not necessary to pursue consensus-building around these questions in the next round. These results will be discussed in the following section.

The ten (consensus) statements that more than 80% of panellists agreed with in Round II, were presented in a table in Round III, where panellists were asked, 'Assuming these statements are true, what would the implications for intervention be for both male and female clients? In other words, how would you address this gender difference within the therapeutic space?' Essentially, this section was to confirm consensus around these issues, and to extract information about the relevance of these issues for intervention, given the misunderstanding around a similar question in Round II. The analysis of this table was conducted with a similar method as was used to analyse the open-ended questions, as each of the statements in the table was treated as its own question, and so TCA was conducted on the responses for each statement, allowing each statement to have a corresponding list of themes, which are presented in the following section.

Round III also included an optional section that presented a table with the seven statements from Round II for which there was non-consensus among panellists, or in which panellists disagreed with the statement. In this optional table, panellists were asked to reiterate their position on the issue (on the same 5-point 'strongly agree' to 'strongly disagree' scale), and the 'composite agree' and 'composite disagree' positions of the group for each statement were listed in an adjacent column (for example, 37.5 % of panellists 'disagreed or strongly disagreed' and 31.25 % of panellists 'agreed or strongly agreed'). Next, a column was provided for comments and panellists were asked to explain their position on each statement, so we could investigate why there was non-consensus or disagreement for each issue. The same method used to analyse the consensus statement table was used to analyse the responses for the optional table.

The average response rate across the four rounds was 89% [completed all rounds = 13 (72%); completed 3 rounds = 3 (17%); completed 2 rounds = 1 (5%); completed 1 round = 1 (5%)].

4. RESULTS

Round I

Exploring gender related factors regarding the experience of torture and its impact

Seventeen (17) panellists responded to the questions in Round I. The final list of themes that emerged from the responses to the open-ended gender questions from Round I are discussed below. Only themes that were mentioned five times or more by the group of panellists are included here (see Appendix I for the full list of themes).

A) THEMES THAT EMERGED REGARDING MEN

– **Link torture and consequences to damaged sense of self/manhood (8 references)**

This theme regarding the male experience intersects with many of the other themes, as certain issues (e.g. abusive behaviour, anger, substance abuse etc.) may be the result of this issue, while other themes may be the cause of this issue (e.g. employment difficulties, sexual difficulties, sexual torture etc.). Additionally, this theme covers many of the same issues covered by 'Male: inability to fulfil gender role,' but also cover other ways that males experience damaged self-esteem in relation to the torture experience.

Two panellists explained that the torture experience (as a whole) negatively affects males' sense of self, and both highlighted that males experience this more severely than their female counterparts. One explained,

> **"Men feel more hopeless and resort to diverse addictions e.g. alcohol, drug abuse, sexuality issues, etc. Others become idlers and lose a sense of direction. Their ego is injured more than that of women."**

Three panellists specifically highlighted the negative impact of the inability to provide for oneself or family due to the torture experience, on male self-esteem. For example, one panellist noted,

> **"Men more often struggle with adjustment difficulties as many find it difficult to find job opportunities to support their families. This seems to be impacting negatively on their sense of manhood."**

One panellist highlighted how males face feelings of failure when they encounter sexual difficulties as a consequence of the torture experience:

> **"Men: feelings of a failure if not sexually active and will project it in anger and sometimes domestic violence, substance abuse."**

Another panellist stressed the impact sexual assault has on male self-esteem, and implied the impact on self-esteem for a male is more severe than for a female after sexual assault:

> **"…sexual assault seems to have more impact on the self-esteem, fear of social contact and isolation for men."**

Importantly, panellists discussed the impact of torture and its consequences, in terms of damaged self-esteem more frequently for males than for females. From these responses, it is possible to hypothesize that males are more likely to feel as though their sense of self has been damaged following the torture experience than their female counterparts.

– **Inability to fulfil gender role (7 references)**

This theme covers the stressors males face in relation to their inability to fulfil the traditional gender role of 'protector/provider,' in the aftermath of the torture experience. Panellists often discussed the male inability to provide as the result of being held in detention (and so separated from family), or in the context of exile, where work is difficult to find. In addition to discussing why the torture experience causes males to be unable to provide for their families, panellists also discussed how they are impacted by not being able to provide, in terms of, but not limited to: guilt, distress, anguish, self-judgment, anxiety, depression, anger, substance abuse etc. The consensus among panellists is generally that the inability to fulfil their role as 'provider' impacts negatively on males' sense of self, particularly in relation to their sense of masculinity, and causes emotional distress, among other consequences. For example, one panellist explained,

> **"Both men and women may experience emotional distress due to separation from family during detention... Given their conventional role as providers, men may experience anxiety or anguish related more intensely to the inability to provide materially... When he ends up in detention in the country of refuge or unable to provide even for himself, he experiences intense anxiety, depression and self-judgment related to failure."**

– **Substance abuse (6 references)**

When substance abuse was discussed by the panellists, it was discussed as a male issue, or as something males are more likely to engage in. For example, one panellist explained,

> **"Men may more frequently succumb to alcoholism and drug addiction which in turn may also cause violence and family breakdown."**

Another stated,

> **"…men feel more hopeless and resort to diverse addictions e.g. alcohol, drugs, sexuality issues, etc…"**

– **Abusive behaviour/aggression (5 references)**

Male abusive behaviour was discussed as a direct consequence of the torture experience, in that it is often a reaction to the pain, anger, insecurity etc. they feel in relation to the torture experience. Additionally, abusive behaviour was discussed as an indirect consequence of torture, in that males often resort to substance abuse as a mechanism for coping, and are abusive as a result of the substance abuse, or they experience sexual difficulties as a direct result of the torture, and are abusive as a result of the shame and anger they feel around their sexual problems.

For example, one panellist explained,

> **"…More men seem to show outwardly aggressive behaviours, often the cause of family violence and abuse of children. Of course abusive behaviour may also be exhibited by female torture victims… Men may more frequently succumb to alcoholism and drug addiction which in turn may also cause violence and family breakdown…"**

Another panellist remarked on abusive behaviour that is an indirect consequence of torture and explained,

> **"Men: feelings of a failure if not sexually active and will project it in anger and sometimes domestic violence, substance abuse."**

– **Sexual torture-experience (5 references)**

Male sexual torture is mostly discussed in relation to the [higher] prevalence of sexual torture amongst female victims, or panellists highlight methods of sexual torture as examples of how the experience of torture is different for females and males. When male sexual torture is discussed, rape, sexual assault and genital abuse are the methods of sexual torture mentioned by the panellists.

B) THEMES THAT EMERGED REGARDING WOMEN:

– **Impact of rape/sexual assault (11 references)**

When panellists discussed daily stressors faced by females, they often framed them in the context of the impact of rape/sexual assault. The social and psychological impacts were focused on the most, with discussion around: social stigma, community and family blame and rejection, STIs, pregnancy, subsequent challenges with sexuality, body image, and intimacy, shame and humiliation, etc.

The following quote illustrates the cultural rejection females often face after sexual victimization:

> **"While shame and humiliation following rape are common to both men and women, there are sometimes gender-specific differences. Women sometimes suffer unique social and cultural consequences, including blame, rejection by a spouse, social exclusion or threats to life and well-being, as a result of stigma and religious or cultural practices."**

The complications associated with [unwanted] pregnancies that result from rape, were mentioned by three panellists, one of whom highlighted,

> **"Pregnancy as a result of rape has severe emotional, physical and social consequences."**

Additionally, the contraction of HIV and other STIs was mentioned by two panellists, one of whom stressed,

> **"The major consequence of politically motivated rape is the attendant risk of HIV, and this has been documented in several Zimbabwean studies. Risks from politically motivated rape increase dramatically with multiple rape incidents."**

It is interesting to note that the impact of sexual torture on females was primarily discussed in terms of the social impact, rather than the psychological. One panellist highlighted that,

> **"…given that torturers tend to torture women in these specific ways [sexual torture and forced to witness torture] their experience of torture is informed by its link to sexuality, intimacy and relating to loved ones. Issues of body image, sexual violation concerns such as shame/guilt and intimacy… are often a feature of their experience of torture."**

– **Sexual torture-experience (10 references)**

The consensus amongst panellists was that while males may sometimes or often experience sexual torture, females are more likely to experience sexual methods of torture, or almost always do. All panellists that discussed this theme either explicitly or implicitly stated that females are more likely than males to experience various methods of sexual torture, or to fear these methods of sexual torture.

> **"Women appear to have more persistent and severe symptoms as a result of torture, but also the consequences of politically motivated rape are mostly unique to women (some cases of males being raped, but not as common)."**

When female sexual torture is discussed, rape, sexual assault, sexual harassment, and genital abuse, were the methods mentioned by the panellists.

– **Challenges for self while sustaining gender role (8 references)**

This theme covers those issues specifically related to the challenges females face while caring for their children which impact negatively on their own healing or recovery. These challenges are discussed by panellists as generally unique to the female experience, as it is their traditional role to care for the children. For example, one panellist explained,

> **"Women are more likely to have responsibility for children when forced into exile. With children come the problems of keeping them safe, feeding, clothing and educating them etc. Also all the challenges of caring for disregulated children when the parent is herself struggling."**

Another panellist discussed that females

> **"…spend all their energy trying to find a way to provide" in the aftermath of the torture experience and so, "the women do not have time to be overwhelmed, so they numb, sideline their needs and keep going frequently leading to depression."**

The responses all highlight how the responsibility for caring for the children often does not allow females the time to focus on their own suffering or trauma related to the torture experience.

– **Inability to fulfil gender role (5 references)**

This theme covers the stressors females face in relation to their inability to fulfil the traditional gender role of 'caretaker of children,' in the aftermath of the torture experience. Panellists who discussed stressors around the female inability to fulfil gender role often explained the inability to care for the children (e.g. inability to care at all or in the manner that they would like) as the result of females being held in detention, or in the context of exile, where there are more barriers to accessing necessary services and assistance in relation to the care of children. In addition to discussing why the torture experience causes females to be unable to care for their children, panellists also discussed how they are impacted by not being able to care for their children, in terms of: stress, fear, guilt, emotional distress, helplessness, anguish, shame.

One panellist explained,

> **"…Given their conventional role as primary caregivers to children, women may experience more intense anguish over uncertainty regarding the safety and well-being of their children. This can be strongest where the woman has had to leave children behind. At a future time of family reunion, the children sometimes have anger and resentment towards the mother for having abandoned them."**

Another panellist highlighted the emotional response females often have to the insecurity around being able to care for loved ones:

> **"Women experience torture as an assault on their social relationships and safety in the world, relationships make them a person in the world, and therefore they feel less able to provide, care, engage, support, love and feel less**

loveable. They feel less of a person and more worried about whether they can care and hold the people who are dependent on them. They feel very ashamed when they are irritable with their children."

– **Lack of social support/isolation/rejection (5 references)**

Isolation was discussed by one panellist as a means by which females 'internalize' the torture experience, in that females isolate themselves as part of their coping process. It was also discussed as a consequence faced by female indirect victims of torture, who try to move on with their life after the death of their husband (who was the direct torture victim), and face subsequent [cultural] rejection by his family and community. For example, one panellist explained,

"…in some cultures if the husband dies, the children belong to the family of the husband. The mother/wife may in that case move in with her in-laws, but if she wants to resume a life of her own (i.e. remarriage, live on her own) she will not be able to take the children with her."

This panellist concluded,

"In summary it seems that women experience more cultural rejection in many communities than men do. This leaves the female gender without social support, much more isolated, all stressors to cope with in addition to the trauma of torture and abuse."

– **Shame/guilt (5 references)**

Panellists spoke of females facing both shame and guilt in the aftermath of the torture experience, which each have slightly different meanings, but are included together because they were often discussed as interconnected. Two panellists discussed that females may experience shame because they experienced sexual torture and are facing the associated stigma that comes with such victimization (although others spoke of this but discussed it as being implanted on them in the form of cultural/social rejection, rather than it being internalized as shame). For example, one panellist explained,

"Women's experience of torture is more often centred round the witnessing of torture of those close to them and sexually-focussed torture…sexual violation concerns such as shame/guilt…are often a feature of their experience of torture."

Another focused on the guilt females experience because they were unable to protect their children from harm:

"Women are sometimes held in detention facilities together with their young children. The children are exposed to conditions of degradation, ill-treatment and possibly direct torture and may be exposed to the torture of others, including their own mother. This can have severe emotional consequences for the woman, including fear, guilt, helplessness and damaged relationships with the children."

The definitions and explanations for each theme that emerged in Round I can be found in Appendix II. The 29 statements presented in the section below were drafted to reflect the consensus opinion amongst panellists with regard to each theme.

Round II

Building consensus regarding gender statements

In this round, the focus was on identifying the areas of agreement and disagreement in relation to gender related statements. These statements emerged from responses in Round I, the literature review, and the IPNs analysis. The tables below present the results from Round II according to the percentage of panellists that agreed with each statement.

Table 1: Gender Statements where >80% of panellists agreed

Outcomes from Round Two: Gender Statements where >80% of panellists agreed	
1	Traditional gender roles are often challenged in the aftermath of the torture experience (for example women becoming the primary providers)
2	Males are more likely than females to engage in substance use and/or abuse
3	Females are more likely than males to experience rape or torture of a sexual nature
4	Females are more likely to be indirect victims of torture (as witnesses, or as family members of torture victims)
5	Females are often forced to develop new skills and take on new roles after experiences of torture
6	Males are more likely than females to present with anger and/or aggressiveness
7	Males are more likely than females to view their inability to fulfil their gender role after a torture experience, as a threat to their personal worth
8	Males and females are as likely to present with Depressive symptoms
9	Females are more likely than males to express their distress (related to crises) to service providers
10	Females are more likely than males to prioritize the needs of their families over their personal needs

Table 2: Gender Statements where 50% - 79% of panellists agreed

Outcomes from Round II: Gender Statements where 50% - 79% of panellists agreed	
11	Sexual torture is linked to increased severity in PTSD, Anxiety and Depressive symptoms
12	Changes in traditional gender roles after torture result in family relationship problems
13	The greatest source of Anxiety for females is in relation to providing for the needs of their family, especially children.
14	Males are more likely than females to be direct victims of torture
15	Females are more likely to experience torture due to the relationships they have with males in their lives, rather than due to their own actions
16	Females show more agency than males in looking for ways to provide for their families
17	Males are more likely than females to report sexual difficulties (such as being unable to perform sexually or loss of interest in sex)
18	Females are as likely as males to experience guilt following a torture experience
19	Males are less able than females to reassume their responsibilities as fathers and husbands
20	The main cause of Depression in females is the fact that they prioritize the family's needs over their own recovery from trauma

Table 3: Gender Statements where <50% of panellists agreed

Outcomes from Round II: Gender Statements where <50% of panellists agreed	
21	Females are more likely than males to report issues of isolation to service providers
22	Males are more likely than females to feel as though their 'sense of self' has been damaged following a torture experience
23	Females are significantly more symptomatic than males (for e.g. anxiety, PTSD, and functional impairment are more prominent in females)
24	Female rape survivors suffer from more severe forms of social stigma than male rape survivors
25	Males are more likely than females to present with despondency and hopelessness
26	Males are more likely than females to report sleeping difficulties (including nightmares)
27	Females in treatment are more likely than males to present with symptoms of avoidance
28	Males are more likely than females to report medical problems, including somatisation
29	Males are more likely to engage in self-harming behaviour than females

Comments from panellists regarding these results can be seen in Appendix III.

Round III

Exploring gender aspects related to intervention

A) EXPLORING WAYS IN WHICH INTERVENTIONS MAY DIFFER IN RELATION TO GENDER

Fourteen panellists responded to this question. Panellists' positions on the first part of the question:

Are there certain aspects of interventions that should differ between male and female clients, can generally be broken down into the following three categories:

- **YES;**
- **NO;**
- **UNCLEAR.**

However, the degree to which panellists' agree or disagree varies, which will be presented below, along with any gender hypotheses and associated implications for intervention that are discussed by panellists.

YES

Seven panellists responded with points that supported the position that gender considerations are relevant for intervention. One panellist did so by noting,

> **"Yes – Sexual violence and issues regarding traditional gender roles in relation to the breakdown of the family and status within society."**

It is important to note here that of these seven panellists, four highlighted sexual violence/rape/sexual assault as the main gender consideration relevant to intervention. For example, one panellist explained,

> **"Sexual assault needs to be understood within the client's meaning system and the meaning frame of her family and community… the therapist must be very careful in assessing the meanings behind sexual assault for that client and for her family and community…"**

The panellist continued to discuss the implications of sexual victimization for intervention, which are summarized as: in societies where there is greater emphasis on the collective and the family, rape may be more strongly experienced as shame or humiliation for the family, thus Western assumptions about rape intervention may be misguided—however, the clinician should never assume the client is from either a collectivist or individualist social structure, but should rather assess what has happened for that woman.

The next panellist discussed rape as the 'only [gender] aspect' that may be relevant to intervention:

> **"The only aspect that I can think of and which is common among female torture victims is rape. This has always been a sensitive and difficult issue to deal with because of shame and guilt that female victims might be feeling at the time when they come through for counselling. What sometimes makes their problem more complex is if they are allocated to a male therapist."**

The next panellist highlighted the significance of culturally informed gender norms to intervention, as well as female vulnerability to sexual victimization:

> **"Culturally-shaped and informed practices have to be seriously taken into consideration. Where I will strongly encourage a male client to aggressively go and seek work, a female client will be asked to be cautious about how this will be done, because this could make them vulnerable to victimization, especially sexual violence. Prospective employers could interpret it as, 'too hungry for a job' that they will agree to giving sexual favours, in the current context."**

Another panellist implicitly agreed that gender considerations are relevant to intervention by highlighting the importance of considering the effect of trauma on the family (a fundamentally gendered social unit), particularly in the parent-child relationship:

> **"It is very important, particularly with women, to pay attention to the impact of their trauma on their relationships with their children… Of course it is also important to pay attention to a father's parenting and how this is being shaped by the trauma he has experienced,"**

The next panellist focused on male emasculation as a gender consideration relevant to intervention:

> **"Unemployment seems to affect men's sense of manhood. Interventions aimed at dealing with this sense of emasculation need to be specific to male patients. Such interventions should help men to challenge how one's sense of manhood is defined."**

This response suggests that interventions should target male emasculation, which is often caused from unemployment.

Lastly, one panellist seemed to agree, but expressed a reservation that a few others expressed more boldly, as will be presented below:

> **"Gender aspects should always be taken into consideration, but it is difficult to say exactly how and when. Trauma might impact men and women differently according to their life situation, this aspect should be investigated."**

NO

Two panellists simply stated 'No' without further explanation.

Another panellist explained,

> **"No for the simple reason the male and female trauma/ torture survivors manifest the same symptoms, even though certain symptoms, in my own experience, seem to appear more frequently in females than in males, e.g., the proneness to cry."**

This response is difficult to analyse, as it responds in the negative, but then provides a gender hypothesis that could be relevant to intervention.

Two panellists suggested that while gender hypotheses may be relevant in certain contexts, there are not systematic gender differences that should indicate different types of intervention.

One explained,

> **"I don't think there are aspects that automatically indicate a type of intervention by gender. Clients and circumstances need to be assessed individually. I do think there are some hypotheses related to gender that can be explored with actual clients to see if they are relevant to that person, context is most relevant."**

This panellist however then noted the following gender hypotheses and implications for intervention:

> **"In some cultures, women are more comfortable sharing emotional issues with each other and men are more likely to prefer to keep things to themselves. This could suggest that women will more readily appreciate a group therapy intervention, whereas men might require more preparation in individual meetings before joining a group."**

Another panellist also suggested gender considerations are not particularly relevant to intervention but then suggested a gender implication for group therapy:

> **"However, when we work in groups, especially in particular cultures, it is better to have male and female groups separately."**

UNCLEAR WHETHER YES OR NO

Two panellists were unclear about their overall position on the relevance of gender to intervention. One panellist stated,

> **"more on cultural gender roles," and then gave the following example:**

> **"When intervention is given e.g. exercise, a female client could have less time due to house chores therefore the therapist has to be creative to encourage family interactions/house chores with the exercises."**

This example seems to signal agreement, but the initial phrasing of the response makes it unclear. However, it does seem to suggest that it is important for clinicians to consider the family responsibilities of female clients when designing interventions, and to encourage family interaction within intervention exercises.

Given the lack of detail, it is unclear to what degree this panellist agreed or disagreed, but the final point about keeping males and females separate in group therapy implies that gender is indeed relevant to intervention.

B) EXPLORING GENDER ASPECTS RELEVANT TO CLIENT-CLINICIAN RELATIONSHIP

The degree to which panellists agreed or disagreed regarding *whether there are issues that clinicians should consider when working with a client of the opposite or same gender* will be presented in relation to the themes below.

– Implications of Sexual Trauma for Client-Clinician Relationship

Eight of the 13 panellists who responded discussed sexual trauma as relevant to the client-clinician relationship, thus implying agreement that there are gender[ed] issues clinicians should consider in the client-clinician relationship, although panellist positions varied.

Five panellists mentioned or implied that in cases of sexual trauma, it is generally better to pair clients with clinicians of the same gender. For example, one panellist noted,

> **"Sexual assault: Trust forms faster in same gender."**

Two more panellists implied that same gender client-clinician relationships may be better, but one did not mention this in relation to cases of sexual trauma exclusively, and the other suggested so in the context of "certain cultures," but suggested in cases of sexual trauma the need for same gender relationships should not be assumed. These reservations will be elaborated on below.

Of these seven panellists who mentioned or implied that same gender client-clinician relationships may be better or necessary, three expressed reservations around such a [absolute] statement, noting particularly that male victims of sexual trauma may have issues with both male and female clinicians. One panellist explained,

> **"While [sexual trauma] is often difficult for clients of either gender to discuss with clinicians of either gender, in my experience, it is more difficult for both men and women when the clinician is of the opposite gender. On the other hand, since the perpetrators are men, some men are intimidated or humiliated to reveal this to a male therapist."**

Another panellist explained that male clients who have experienced sexual trauma might require more sensitivity regarding the client-clinician relationship than their female counterparts. This panellist explained,

> **"For male client –female therapist, the client may feel embarrassed to share this experience of rape as a male client to a female therapist. The same also applies to a male therapist that the male client may also feel ashamed to share his rape experience with a male therapist."**

Another panellist, after explaining he/she would likely assign a female client with a female therapist in cases of possible rape explained,

> **"Male clients may do better with male therapists, although they often do equally well with female therapists… If sexual abuse is suspected in a male they may trust a male therapist better with this issue, although not in all cases. As an older female I have worked successfully with numerous survivors of male rape."**

Interestingly, in contrast to the panellist positions above, one panellist noted that,

> **"[With regard to] certain female trauma, e.g. after rape, [it] might be inappropriate to work with a male clinician – but you need to ask the client specifically. Usually men are less affected by the gender of the clinician than women."**

The panellist who suggested same gender relationships may be necessary in 'certain cultures,' but should not be assumed to be necessary in cases of sexual trauma explained,

> **"There are many cultures that make it very difficult for women to talk with men – particularly talk intimately with men and this needs to be respected…Certainly women may struggle to disclose sexual assault to a male therapist – but I think there is sufficient evidence to suggest that this should not be assumed – and that there is great value in working through these complex transference and countertransference dynamics that may be evoked."**

This panellist was the only to note that it may be valuable to work through 'transference and counter transference' issues, while these same issues were a reason most of the panellists explained that same gender client-clinician relationships would be better in cases of sexual trauma.

– **Implications of Cultural/Traditional Gender Roles for the Client-Clinician Relationship**

One panellist mentioned,

> **"…Another issue is attitudes of male supremacy among male clients. Some male clients come from cultures that devalue women and have personal attitudes that devalue women, and they may disrespect or discount the capability of female clinicians… In my opinion, agency policy should not accommodate attitudes of male supremacy, if expressed or exhibited, by changing therapists – rather by dealing with this directly to the extent necessary,"**

implying agreement that there are gendered issues to consider in relation to the client-clinician relationship. This panellist also noted,

> **"As part of developing a trusting relationship, all therapists have the option of asking the client how they feel about meeting together, and both male and female therapists may ask specifically about the gender issue."**

The idea that clinicians should ask the client directly about the gender issue was also noted by two other panellists, one of whom explained,

> **"The unique issue that the clinician should consider when working with a client is to know whether he or she has a gender preference. The fact is that gender is not a significant factor in therapy, and the client alone can make it an important issue to take into consideration."**

This panellist, unlike the other who suggested clinicians ask the client about their gender preference, does not think gender is relevant to the client-clinician relationship unless the client makes it an important issue. The idea that gender is not a crucial issue to consider will be explored in the theme below.

As discussed under the theme above, one panellist noted that,

> **"There are many cultures that make it very difficult for women to talk with men – particularly talk intimately with men, and this needs to be respected in the client-clinician relationship."**

– **Gender not Significant to Client-Clinician Relationship**

Five panellists noted a degree of disagreement that there are significant gender issues to consider regarding the client-clinician relationship, or explained that gender may not be the most relevant issue to consider.

One panellist responded that,

> **"These gender issues reflect more general issues within a therapeutic relationship in relation to countertransference and the impact of cultural and contextual frameworks on the therapeutic process. In as much as race, language, age, and culture are issues within the counselling relationship, so too is gender. It is important for the clinician to be attuned to the impact of such issues within the unique context of any particular therapeutic relationship and address the impact of these factors where required and appropriate."**

Also discussed above, another panellist noted that the client alone can make gender an important issue, and so the clinician should only consider whether the client has a gender preference. This panellist also explained,

> **"If the therapist is skilful and experienced, which implies that he or she is able to maintain appropriate boundaries, and the client does not have any gender bias, the therapy would progress well. In case difficult issues arise from the therapeutic relationship, the therapist is advised to address them in supervision or peer consultation."**

Thus those that expressed hesitation to agree with Question 2 believed: Gender is often not the crucial difference to overcome in client-clinician relationship; Gender issues reflect more general issues around the impact of cultural and contextual frameworks on the therapeutic process; Issues clinicians should consider are highly variable on clients' history and social and cultural context (not systematic issues); Clinicians should ask client specifically about the gender issue as the client alone can make gender an important issue for clinician to consider.

C) IMPLICATIONS FOR REHABILITATION FROM CONSENSUS STATEMENT TABLE, ROUND THREE - GENDER ELEMENTS THAT COULD BE PRESENT AND RELEVANT FOR REHABILITATION

While the section above presented the results from Question 1 and 2 in Round III, the discussion below presents the results from the 'Consensus Statement' table in Round III. Here, the main themes that emerged in relation to implications for treatment are discussed. These were extracted from panellist's comments regarding the ten consensus statements (See Methodology section).

– **Nature and/or focus of support according to gender**

Here, panellists discussed how males and females may require different areas of focus for rehabilitation. For example, some mentioned the need to support females in coping with new roles and grieving:

> **"Females might carry a heavy burden looking after their tortured men and at the same time take care of the children. They might need as much support as the direct victim." Deal with her own vulnerability and bereavement issues, as well as how to contain her children if they are struggling to cope. Support female in taking on role as provider, understanding it may burden the client."**

Attention was also given to the fact that indirect victimisation should not be equated to less severe outcomes. As a panellist describes:

> **"Consequences are severe, just as direct victimization, and can include PTSD. Make no assumption that this is less traumatic…does not mean that female clients are less affected than male clients."**

The focus of support can be different according to gender. One panellist describes how one needs to:

> **"Provide support to the female client in her new roles, and help the male client define roles for himself."**

In relation to men, panellists referred to the importance of rebuilding self-esteem / masculine identity:

> **"Provide re-assurance that the inability [to provide] does not make them less of men; Issues of masculine identity would need to be explored with these male patients; develop practical solutions to change in gender role, such as integrate client into an employment programme, and it is important that male clients be involved in productive activity as it enhances self-worth."**

Panellists cautioned against assuming that anger and aggressiveness are only present in men. For example, one panellist stated:

> **"Many females are seen to present with anger and aggressiveness. This is often directed to their children."**

– **Dealing with sexual violence**

In relation to this key component of torture, panellists described the importance of being aware of the possibility that a female client has been raped.

> **"Sensitively and appropriately assess in every case; Pay attention to sexual material when assessing female clients; be aware of possibility when exploring a trauma history; explore vulnerability of the female client."**

This may have an impact on who clients are more comfortable to work with, namely male or female clinicians. This can be approached by allowing the,

> **"Client to choose between female and male therapist; females prefer to be assisted by someone of the same gender."**

In terms of men, one should keep in mind that males may be less likely to talk about it:

> **"If men have been raped or sexually assaulted this needs to be very carefully approached; be aware that men often are exposed to sexual torture, but might not tell about it."**

Panellists also described the complexities involved in working with female victims of sexual torture.

> **"(Be) alert to the indication of current relationship and sexual problems as a "symptom" of sexual trauma, particularly in females; be aware of the potentially stigmatizing nature of this experience--client unlikely to disclose unless they feel safe with clinician, and that the clinician understands humiliation/stigma for both client and her family; let female know they are not expected or required to talk about everything that happened to them before they are ready; female-only group sessions; issue of rape is more difficult for females to discuss in Muslim countries; rape survivors will need more privacy and will take longer to establish trust-- often sexual trauma is only revealed at later stage in the counselling relationship; work needs family support at the end."**

– **Managing Depression**

Depression emerged as a key component of torture rehabilitation. Panellists spoke about the gendered aspects of depression, saying that:

> **"Although males and female are as likely to present with depressive symptoms, it is however more common among females because of the multiple roles they need to play."**

Despite this, panellists described ways in which depressive symptoms should be managed, regardless of gender:

> **"Treatment intervention as appropriate depending on the circumstances, symptoms, strengths, resources and history; Follow-up on any indication of thoughts of self-harm or suicide; Provide psychotherapy to those presenting with Depressive symptoms; Empower them to be able to carry out the exercises on their own and out of sessions; Cognitive therapy can be very helpful; Symptom-management will need to address the differences in the way men, and women, experience depressive symptoms."**

– **Support/Assist women in balancing own needs with needs of family**

Panellists described ways in which women place the needs of others in front of their own and the importance of addressing this:

> **"It is important to pay attention to circumstances in which women inappropriately devalue themselves and discount their own needs in subordination to husbands and children; this assumption is often true because of the nurturing role that mothers have to play; this is a broader issue regarding traditional gender roles."**

The ways that this could be addressed include:

> **"Sensitive and gradual attention in therapy, starting with identification of the types of emotional and behavioural problems the woman is experiencing as a result of prioritizing the needs of others. Then work towards a balance without implying that there is something wrong with her devotion to her family; Normalize with time to avoid a situation of burn out for female; Help them to understand this within a group setting of women only; Ensure adequate self-care on the part of the female client, as well as an empathic and supportive understanding of her role within the family; More social programmes to target women who will not seek help as they concentrate on providing for the family."**

– **Gender differences in the expression of distress and emotions**

This theme related to the different ways in which men and women express their distress and emotions. As one

panellist stated:

> **"There is an assumption that it is generally easy for females to express their emotions unlike males because they do not have any anxiety about being labelled as weaklings."**

This notion of distress being seen as a sign of weakness was echoed by another panellist:

> **"They may suppress it and feel it is a sense of masculinity. They may not want to be seen to be weak by expressing their distress to service providers; Useful to acknowledge with men the fact that we are often trained to be strong and to view expression of distress as weakness. Acknowledging this without judgment can create room to explore distress without feeling inadequate."**

Others were quick to highlight that males may experience more distress than they acknowledge or realize:

> **"Give enough time to males (just as to females) to express their distress; the clinician might have to be more specific in his/her questions to men than women."**

An important reflection regarding this was that both genders can share distress in a trusting relationship:

> **"I have found that both males and females can usually share their distress with counsellors. The males may initially need a little more prodding and patience, but they too will talk freely provided the trust is being established and they feel safe."**

– **Adjusting to changes in roles and circumstances in the aftermath of torture**

Two main sub-themes emerged here, one regarding the need to recognise and explore changes experienced and another focussing on addressing these changes.

Panellists highlighted the need for exploring the nature and impact of change for victims of torture and not assuming that these are obvious to clients.

> **"Sometimes clients may be experiencing this without realizing it; let client explain effect of change on client and family; if it is a problem, discuss with client why it is, explore/suggest perspectives on changes."**

For men this may be linked to feelings of emasculation:

> **"Emasculation due to no longer being able to provide for or act as head of family and/or when the woman becomes primary provider, with impact of: become isolated from family, exhibit abusive behaviour;"**

For women change may look slightly different:

> **"Women take on unaccustomed roles for which they may feel unprepared or not permitted; Females are forced to play both mother and father roles at the same time-- this expectation often causes a lot of stress and strain on the mother. There is always anxiety about coping."**

Panellists outlined the need to specifically address the impact and loss associated with change by:

> **"Normalize psychological response to change; let client explain effect and feelings around change; empower client through psycho-education on cause for change and importance of family unit, as well as effect of changed roles on wellbeing; consider it takes courage to admit how daunting new roles are, and may take clients time to realize enormity of new role; address impact of change on social relationships, include couple counselling; heterogeneous group therapy; supportive counselling for female clients; include income-generating activities as part of rehabilitation."**

For males, it will be important to address impact on male's sense of self-worth in psychotherapeutic process:

> **"The males can be assisted either in individual, group or family therapy to come to terms with the new roles and their inability to fulfil role expectations; exploration of feelings."**

Additionally, in managing the ways in which loss is linked to male emasculation there is a need to:

> **"…address impact by focusing on self- esteem and exploring ways in which male client can cope with roles reversal; CBT to help male clients regain their traditional roles if possible or to accept new roles."**

Female specific interventions were also mentioned including:

> **"Explore emotional conflicts that may arise as women take on unaccustomed roles for which they may feel unprepared or not permitted; explore how to take on new roles without feeling bitter or that they are going against the expected cultural standards; their strengths need to be reinforced; Supporting them in their new role as well as supporting the husband in his."**

Practical solutions should also be sought for both genders in relation to coping with change:

> **"Training on new skills for empowerment; Technical skills enhancement and provide livelihood opportunities for them as part of rehabilitation."**

– **The importance of family support and involvement in rehabilitation**

Here the main themes revolved around the importance of recognising the impact on the family and on including the family in supporting the client.

> **"The family aspects of this are important to address. Consider what this means for the children."**

Male clients may display more aggressiveness or anger which could be directed towards the family:

> **"They might be abusive towards their wife and children, the clinician need to be very aware of this aspect in order to provide the relevant help to the family; Assessment on the effect on the family."**

If a male client's self-worth has been impacted, this may affect the family, especially the spouse and on his ability to parent.

> **"Where there is a couple involved, it is important to include the wife in this discussion, as it likely impacts the marital relationship; Work carefully with impact on parenting – help them to see the importance of fatherhood."**

The need to involve families in intervention was a key theme. This was seen as especially important for females who place family needs over own:

> **"It is important in coming up with treatment or intervention plan that will ensure that family members of the female clients are also given support."**

It may be necessary to think and work systemically:

> **"Through systems therapy, find out the spouse response and change after trauma. Skills to support spouses."**

Treatment of depression in particular, may require the involvement of family members:

> **"Might have different implications for the family and this should be taken into consideration; symptom-management will need to address the differences in the way men, and women, experience depressive symptoms. This is especially important when the partner is present. This is also the reason why couple counselling is very important."**

– **Providing psycho-education and normalising symptoms**

A common theme regarding implications for intervention related to the provision of psycho-education and the importance of normalising symptoms for clients. Many of the points here related directly to gender. One theme to emerge here was in relation to change in terms of the ways in which gender roles are challenged in the aftermath of torture, including ways in which females are often forced to develop new skills and take on new roles after experiences of torture and the need to recognise and normalise this:

> **"Explain change is due to experience/impact of torture, but also that gender roles are dynamic and change with time, so this experience is inevitable."**

Another theme to emerge was the need for psycho-education in relation to different aspects of torture. This included the prevalence and impact of sexual violence:

> **"Educate female client that sexual abuse is common in this situation, and describe common feelings/impact so to provide space for her to acknowledge if it has happened."**

The links between torture experience and anger or aggressiveness were also highlighted along with the need to do psycho-education about the role of alcohol/drugs in coping with trauma, especially for men:

> **"Focus on the consequences of engaging in substance abuse; psycho-education on how men deal with trauma."**

Finally, doing psycho-education in relation to direct victimisation and its impact was seen as necessary to do, mainly with female clients:

> **"Empower the females on protection measures; on care for caregiver to avoid burnout; explaining the impact of indirect exposure to torture; crucial because indirect victims could also present with the same post traumatic stress symptoms as direct victims."**

– **Assessment**

The need for individual assessment to decide on intervention was a key theme. Panellists mentioned a number of areas that should be assessed, with a focus on the ways in which the person has been impacted. Some of these themes were not directly discussed in terms of gender, although could have gender links given the discussion above. For example, the suggestion made to assess for the presence of anger or aggressiveness:

> **"Assessment should include explicit investigation of emotional and behavioural manifestations of anger/ aggressiveness; introduce during an assessment in a non-threatening manner."**

Depression was also seen as an important area to assess:

> **"Routinely assess for depression, using clinical interview and a symptom checklist; an awareness of depressive symptomology and the appropriate management and treatment of it is an essential component of work with torture survivors."**

The presence of substance abuse and the client's willingness to address it was also mentioned. The assessment of substance abuse was further addressed as a male-specific issue:

> **"Assess proactively for this, especially with male clients; dependent on the culture, generally males are more likely to engage or they talk about it more freely."**

Male clients' self-esteem was indicated as an important aspect to assess as one panellist described:

> **"One would need to focus on self- esteem. Societal expectation is that men are required to provide for their family. If they are unable to fulfil this role they could be labelled as failures."**

Others noted the importance of being sensitive to gender differences, especially in terms of assessing for indicators of male distress:

> **"Clinicians need to be aware of these gender differences and be responsive and attuned to the client and respond empathically within the client's frame of reference; Assess for behavioural evidence such as sleep disturbance, difficulties in concentration or functioning, etc."**

Female specific aspects to assess were linked to ways in which female clients have had to take on new roles or learn new skills. Finally exploring whether the person was a direct or indirect victim was also mentioned:

> **"Explore as part of a trauma narrative. Feelings of shame, guilt and helplessness may be more prevalent in indirect victims of torture."**

– **Focus on the development of healthy coping responses and approaches**

There was a clear pattern of emphasising the need to focus on positive coping responses in working with victims of torture. This was especially evident with regards to coping with change:

> **"Empower client to share roles; Help client reframe, find resilience and strength in this new challenge; focus on self-esteem and explore ways for males to cope with roles reversal; encourage change, especially if this is not causing any stress for the patient."**

Other panellists mentioned more practical solutions to address change:

> **"Problem solve and skill build around new skills needed for new circumstances; Learn new healthy roles as therapy goes on with healing process; incorporate treatment with the livelihood activity; income-generating activities."**

Male specific aspects of this focussed on anger management and the need to challenge notions of masculinity:

> **"The man needs to be made aware that violence is not acceptable; explore alternative ways to deal with their aggression; rather than go directly to talk therapy, self-expression could be used first to provide venue for catharsis; help males to process and integrate the effect [of torture] on their dignity, masculinity, vulnerability; Males may require more focused exploration of their anger and aggression; Processing anger in groups or individually helps clients to better understand it and assists them with parenting issues to help divert their anger or to deal with it differently."**

Two aspects relevant to both genders were mentioned, namely:

> **"Concern for family is a positive quality, which should be valued and encouraged in both men and women; both genders need help to look at the needs of their families, but also look at being able to fulfil their own needs."**

and providing support mechanisms for substance abuse (despite the fact that substance use was mainly discusses as a largely male impact):

> **"Heterogeneous group therapy to empower both genders; Can also have individual counselling with the affected clients—Use CBT to empower the clients, Manage substance abuse before trying exposure therapy; On-going complex treatment that should be managed by torture treatment centre – need to build these additional skills."**

D) THEMES FROM OPTIONAL TABLE, ROUND III

The following are the results from the optional table in Round III. These responses are more relevant to impact, as panellist responses were explanations of why they did or did not agree with each of the statements that represent potential gender differences around torture impact. Responses are organized around the degree to which panellists expressed agreement or disagreement with the gender statement.

STATEMENT 1:

Female rape survivors suffer from more severe forms of social stigma than male rape survivors

- **Agree: Impact of female stigma is more severe than stigma faced by males**

Two of the six panellists that responded expressed a degree of agreement with this statement. One explained,

> **"This is objectively true. Women are often excluded from society, blamed for the rape and defined as ruined and useless by virtue of having been raped. They are sometimes deemed unfit for marriage, and even killed for the "shame" they have brought on their families. To my knowledge, whatever the stigma or isolation that male survivor's experience, it does not reach this level of objective destruction."**

The other noted,

> **"With female rape survivors the social stigma is more far reaching, influencing their abilities to remain married or to marry if they have not been married previously. They will suffer more isolation than possibly a male sexual abuse survivor. The consequences of a male sexual abuse survivor is less far reaching from a social point of view."**

- **Dependent on social context**

> **One panellist noted that this "depends on the community," implying that the social context is more relevant than gender to understanding the degree of stigma rape survivors face.**

- **Gender difference misleading: Less recognition and documentation of male sexual victimization**

  One panellist explained that,

  > **"Males do not talk about their stigma," and thus "there is more documentation on the issue [female rape] than there is in male cases,"**

  which could explain the impression that females suffer from more severe stigma. Similarly, another noted,

  > **"This is because of the stereotype, so that when a female admits to being tortured, she is then boxed into being a rape victim. Meanwhile, this is not a man's experience (being boxed into a [rape] category)."**

- **Disagree**

  > **One panellist noted, "That is not my experience," without further explanation.**

STATEMENT 2:

Males are more likely than females to present with despondency and hopelessness

- **Disagree: Both genders present with this**

  Two of the eight panellists that responded expressed disagreement with the statement, both stating that both genders present with these feelings or behaviours. One explained,

  > **"In my experience, some people of both genders present in this way, not more one or the other."**

- **Agree**

  Three of the eight panellists implied agreement, but for varying reasons. One panellist connected male despondency to the inability to fulfil the male gender role:

  > **"This may be due to the fact that they [males] are unable to assume their responsibilities as before."**

  Another panellist expressed agreement, noting that:

  > **"Men seem to be more able to "cop" out of life… and be miserable, whereas women tend to carry the problems of their families. Yes, I do think women become depressed when they subvert their needs for their family… but I think it's more of a numbed exhaustion, than a more energy intensive despondency."**

  The other panellist focused on female resilience as the explanation for the difference:

  > **"Females connect easily with other female[s] and find strength in shared problems [more] than males do. Female[s] will naturally nurture and find themselves [more] productive than males would."**

- **Unsure or position unclear**

  One panellist felt unable to comment because s/he did not have enough exposure to this to decide. Another shared a comment that did not clearly relate to a position around this possible gender difference.

STATEMENT 3:

The main cause of Depression in females is the fact that they prioritize the family's needs over their own recovery from trauma

- **Disagree: Problematic to assume this given traditional female gender role**

Three of the seven panellists expressed to some degree that the statement is problematic in that it misrepresents the impact on females of caring for one's family. For example, one panellist noted,

> **"I think this statement implies there is something wrong with valuing your family highly and blames women for some defect in their attitudes that leads to depression…"**

Another explained,

> **"Females are naturally nurturing and hence their productivity is seen from the eyes of caring. Lack of it causes depression,"**

which implies that the ability to care for one's family saves females from depression, rather than causes it. Another noted,

> **"A women's sense of self is deeply rooted in fulfilling her gender roles, and as the family's main carer, the needs of their children is of outmost priority…"**

- **Disagree: Varied causes for depression, not one explanation**

Four of the seven respondents suggested that the causes for depression are complex and cannot be reduced to one cause. One panellist explained,

> **"…Some of the main causes of depression in women, as in men, are reaction to loss, reaction to abuse as well as physiological and biochemical predisposing factors, including post-partum depression. An additional component is the devaluation of women by male supremacist cultural and social attitudes and practices – honour killings being an extreme example of prejudice and abuse that is widespread in less extreme forms."**

Another discussed that,

> **"I definitely agree strongly that this is a factor, although I'm not comfortable with the statement that this is the main cause… I think that where a woman's children are dependent on her to find resources in order to survive and she has to place all her energy in securing basic necessities – depression is a likely response in part because she does not have the available energy for strong trauma reactions or intrusions to develop. But I think it's problematic to say this is the main cause… because it is likely to be far more complex than that."**

- **Worry about family needs can be positive**

One panellist noted both that the causes for depression are many, and that the cause proposed in the statement for female depression could actually be helpful in the healing process.

> **"Depression in females can be caused by many reasons. It could be their own losses (family members, homes, etc.) Sometimes having to worry about the needs of their own families may actually help in the healing process."**

- **Agree: Challenges of family care**

One panellist expressed implicit agreement and noted,

> **"To care for the family in the country of asylum is already a very tedious task, and the females doing that have unresolved trauma to live with."**

STATEMENT 4:

Females are more likely than males to report issues of isolation to service providers

- **Disagree: Gender difference is not relevant**

  Two of the five panellists that responded expressed that the gender difference captured by the statement was irrelevant or inaccurate. One panellist noted,

  > **"Females are more likely to make use of social supports in their environment, especially other women. That said, I would not say males are more likely. In my experience, some people of both genders present in this way, not more one or the other."**

  This also highlights an issue captured by the theme below, that females are more likely to make use of social support and thus less likely to isolate. Another panellist highlighted that social context is more relevant than gender:

  > **"This is dependent on the social context. Where the environment is highly xenophobic and/or homophobic, determines the degree of isolation experienced."**

- **Disagree: Males more likely to isolate**

  Two of the five panellists stated explicitly that males are more likely to isolate. One noted,

  > **"Since the women have to deal with their children, they are less likely to report isolation. More men seem to isolate themselves from family members and from community."**

  Another explained that females are more likely to make use of social networks, and thus less likely to isolate.

  > **"Women seem to retain or recreate social networks more easily than men. I would expect men to report more issues of social isolation."**

- **Disagree: Females more likely to make use of social support/networks**

  Both panellist statements that expressed this are presented above.

STATEMENT 5:

Males are more likely than females to feel as though their 'sense of self' has been damaged following a torture experience

- **Disagree: Both genders likely to feel sense of self damaged**

  Two of the seven panellists that responded suggested females are just as likely to experience this. One explained:

  > **"Women are just as likely to feel their sense of self damaged. Sexual torture often if not always damages the sense of self, and women more often than men endure sexual torture."**

  This is relevant to the theme below, and could also suggest that females are more likely to experience damaged sense of self as they more often endure sexual torture. Another panellist noted:

  > **"Males and females are equally impacted with regard to torture's damage to their 'sense of self.'"**

- **Sexual torture damages the sense of self**

  Three of the seven panellists suggested the type of torture is more relevant to understanding the degree to which victims' sense of self is affected, and all noted that sexual torture is particularly damaging. For example, one panellist explained,

  > **"Much of it depends on the types of torture they experienced. Sexual torture and rape, for example is very damaging to both males and females."**

  Another highlighted the relevance of damaged sense of self to females, particularly when they have been sexually victimized:

  > **"Females' sense of being a woman, and fulfilling gender roles, are shattered during a torture experience, especially when there has been any sexual assault."**

- **Gender not useful when evaluating likelihood of damage to sense of self**

  One panellist noted,

  > **"I think this is really hard to organize around gender… this relates to an individual's meaning system – and both men and women find meaning in their gender roles. To compare this is … not useful. This is needs to be assessed and worked with on an individual level."**

- **Agree: Male direct victimization explains damage to sense of self**

  Only one panellist of the seven expressed a degree of agreement and explained:

  > **"Males are most of the time direct victims of torture and their inability to resume their roles is an additional factor to consider."**

- **Unsure**

  One panellist noted that his/her position was inconclusive.

STATEMENT 6:
Females are significantly more symptomatic than males (for e.g. anxiety, PTSD, and functional impairment are more prominent in females)

- **Disagree: Gender not significant re degree of symptoms**

  Two of the five panellists that responded suggested that both genders present as symptomatic. One noted:

  > **"In my experience, some people of both genders present in this way, not more one or the other,"**

  The other highlighted individuals' systems of meaning-making as more relevant to determining how one experiences symptoms:

  > **"Males and females are symptomatic, dependent on how the torture has been framed in their minds, meaning-making as an important determinant."**

- **Disagree: Women are more likely to report symptoms, but symptoms present in both**

  One panellist explained:

  > **"Females are seen by the society as weak. They find it more easy to talk about their problems than men do. However symptoms are present in both. The lack of talking about them does not mean there are no symptoms."**

- **Disagree: This gender difference cannot be applied broadly/globally**

  One panellist noted,

  > **"I don't think this global statement can be true…. Women and men are different."**

STATEMENT 7:

Males are more likely than females to report medical problems, including somatisation

- **Disagree: No significant gender difference**

  Two of the seven panellists that responded expressed disagreement that there is a significant gender difference around somatisation. One noted:

  > **"In my own clinical experience, clients (males and females) have no particular difficulty to report medical problems."**

- **Disagree: Females more often report somatic problems**

  Three of the seven panellists disagreed with the statement and instead suggested that females are more likely to report somatisation. One panellist noted:

  > **"Females more often report somatic problems. Males sometimes report somatic problems."**

  Another explained,

  > **"Females are more sensitive to how their body feels and seek medical help for the slightest complaint, while men would wait until when the illness causes extreme dysfunction, before seeking help. The stereotype that men should not be wimps and cry with the slightest problem."**

  This highlights issues around masculinity as a reason that males may not report. Another panellist suggested that males are more likely to respond to trauma through substance abuse, while females are more likely to report somatic complaints, but also noted both males and females suffer from chronic illness due to unresolved trauma:

  > **"I think men tend to use substances and women tend to respond with strong unique symptoms of somatization – e.g. Headaches, pains. Men for instance have a much lower level of approaching health facilities within most South African contexts and this is linked. I think both men and women tend to suffer from increased chronic illness as a response to unresolved trauma."**

- **Unsure**

  One panellist only stated that this was not their experience while another maintained his/her position, saying:

  > **"90 % of our clients are male and these are observable to most of them."**

5. CONCLUSION

This report provides the beginnings of an exploration of the way in which gender may be relevant in how torture is experienced, its impact, and its rehabilitation. It highlights some important aspects of gender as it relates to torture and assists in exploring the implications of these on treatment.

The report has a number of limitations and its results should be understood in light of these. Gender was not initially included in the conceptualisation of the project given the limited resources available to explore the already complex goals of the project. The inclusion of the gender questions emerged when a Masters Student and intern at CSVR (Rachel Goodman) became available to assist. The project and her area of study coincided and the project was then expanded to include gender questions. Given this, the methodology used may have not been the most ideal. The importance of this issue calls for research to be done which focusses specifically on gender and not as an add-on to other studies. The limited time available to focus on this aspect of the research also may have impacted on the quality of the report. Despite the limitations, the report provides useful information and insight into the way in which practitioners in the field of torture understand gender.

It should be noted that throughout the responses provided, panellists repeatedly stated that each case or client should be seen as unique. So, although gender may be important and certain aspects of it may influence outcomes, there will always be exceptions. Through this, the panellists caution against all-or-nothing thinking when thinking about gender differences and/or similarities. Indeed, the gender factors explored here should be seen as things to consider by those in the field. In line with this, panellists highlighted the need for detailed assessment of all torture victims.

The report points to a number of factors to consider when working with male torture survivors. Firstly, torture and men's inability to fulfil gender roles subsequently may impact on their sense of self or manhood. Secondly, the use and/or abuse of substances were seen as more common in male torture survivors. Thirdly, men may experience more evident levels of anger and/or aggressiveness. Fourthly, depression may emerge in men. Lastly, men may present with less obvious ways of expressing emotions and distress.

In relation to female victims of torture, a central factor to consider is the experience of sexual violence as part of torture and its consequences. Secondly, shame and/or guilt may emerge in the aftermath of torture. Thirdly, their ability to cope or recover from their torture is influenced by the challenges of caring for their children, which is linked to the fourth factor of not being able to fulfil their gender roles and the distress that is experienced as a result. Fifthly, panellists highlighted that women are often likely to place the needs of their families in front of their own (which was not always seen as negative). Lastly, female victims are often forced to develop new skills and take on new roles in the aftermath of torture.

Panellists spoke of the need to look beyond the experience of torture alone when working with victims as the impact of displacement experienced afterwards can often be significant. The impact of these stressors can also be felt similarly by men and women.

Sexual violence emerged as a main theme throughout the report. Although panellists agreed that this was more likely to occur for women, they highlighted a number of reasons for why men are less likely to report and/or speak about it. In relation to its impact, panellists agreed that it is equally devastating to victims regardless of gender. They also cautioned against assuming that all female victims of torture have been raped or assuming that if men do not mention it, that they have not been victims of rape. Either way, the matter should be approached with caution and the complexities of this work were made evident.

Although some panellists did not consider gender as significant in the client-clinician relationship or that it was something that could be easily and proactively managed, others pointed to some aspects that may influence intervention. Traditional/cultural beliefs held in relation to gender could affect the client-clinician relationship and should be explored and worked through with the client. A number of panellists felt that given the complexity of working with sexual violence in torture victims, it was often better to pair clients with a clinician of the same gender. At the same time, others noted that this is not to say that a cross-gender relationship could not be successful, but it would require additional care.

The last section of the report explored areas in which the panellists did not reach consensus. This section is especially interesting as it points to the fact that this work is complex and therefore generalisations become difficult to make. It also highlights the variety of experience in the field and the need to look at contextual factors at play.

It is clear that further research into this facet of torture is needed. Although various aspects mentioned in this report could be explored more systematically, the lack of literature available on male sexual violence is particularly concerning. The complexity involved in the treatment of sexual violence used as torture for both men and women should also be explored.

It is hoped that this report will assist practitioners in the field of torture prevention and treatment by illuminating the ways in which gender and torture interact. Being aware of some of these aspects could improve the treatment offered. In general, sensitivity to each individual client is suggested. All gender-related aspects will be influenced by particular contextual, interpersonal, and individual factors.

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