



# Torture Treatment Literature Selection, Q4 2016

The PATH literature bibliography is a resource for current literature on the topic of the mental health status of and treatments for torture survivors, war trauma survivors, refugees, and asylum seekers. This also includes research in the areas of social work that relate directly to the psychological wellbeing of these populations. The bibliography includes peer reviewed journal article citations in these areas; select original summaries of those articles; and links to the publicly available abstracts and full text versions of these articles. This bibliography is updated and distributed on a quarterly basis. The bibliography does not currently include articles on policy and advocacy.

### CVT Volunteer Contributions to this Bibliography

- **Carolyn Easton** conducted the literature search and compiled the citations for this bibliography.
- **Ellie Lewis** organized, formatted, and edited the content of this bibliography.
- **Eden Almasude, Frank Hennick, Marissa Wood-Sternburgh, and Ann Zedginidze** wrote summaries of selected articles for this bibliography.
- **Jared Del Rosso** reviewed the selected article summaries for this bibliography.

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## Selected Article Summaries

### Posttraumatic Stress and Depression in Yazidi Refugees

Summary by: Marissa Wood-Sternburgh, Volunteer with the Center of Victims of Torture

Nasıroğlu, S., & Çeri, V. (2016). Posttraumatic stress and depression in Yazidi refugees. *Neuropsychiatric Disease and Treatment*, 12, 2941–2948.

#### Study Details

"Refugees are people who cannot return to their countries, due to a well-founded fear of persecution because of their race, religion, nationality, social group, or political ideas" (Nasıroğlu and Çeri, 2016, p. 2941). This includes adults and children, though studies on refugee children and their integration into their host countries is limited. Even so, we know that approximately 11 percent of refugee children exhibit post-traumatic stress disorder (PTSD). This study aims to determine the frequency of mental pathologies in children (6-12 years old), and adolescents (13-17 years old) of the Yazidi minority group who immigrated to Turkey from Iraq following assaults by the Islamic State in the Sinjar region of northern Iraq.

#### Study Sample

Fifty-five children and adolescents (30 males and 25 females; 32 children and 23 adolescents) who were Yazidi refugees that settled in the villages of Batman, Turkey, were evaluated in their native language (Kurdish). These evaluations occurred nine months after immigration. They were evaluated for depression, PTSD, nocturnal enuresis, and other mental pathologies.

#### Study Findings

PTSD was detected in 36.4 percent of participants (20 participants); the study did not give a breakdown of the number of children and adolescents who showed symptoms. Previous studies have found PTSD rates among refugees to vary between three and 37 percent, depending on country of origin, culture, norms, and coping strategies. A major risk factor for PTSD was witnessing violence and/or death; 14 participants reported seeing someone being exposed to ill treatment or being killed, and 25 had seen a wounded or dead person.

Depression was detected in 32.7 percent of participants (18 participants). Adolescents were diagnosed with depression significantly more than children, possibly due to the stress of having more responsibility to take care of their family. The researchers noted several risk factors associated with depression, including witnessing violence and/or death, being a girl, having older parents, being the elder child, and having multiple siblings.

Girls were much more likely to be diagnosed with mental health disorders than boys in this study, which is consistent with previous studies. Girls reported higher rates of concern than boys for those left in Iraq. They were also more likely to respond "yes" to the question, "was anyone near you during the war/migration wounded?" The higher rate of mental health disorders in girls is thought to be because of girls being less socialized than boys into village environments in Turkey.

#### Conclusion

Based on the study's results, the authors concluded that social support for these children and adolescents should be increased, schooling should be provided, and discrimination from the press needs to stop. (There was no further discussion of the nature and prevalence of press discrimination against refugees in Turkey.) Girls and adolescents are at a higher risk than boys and children, but larger-scale studies should be conducted to help detect risk and preventative factors that can cause or decrease mental disorders amongst refugee youth.



## Attachment style and interpersonal trauma in refugees

Summary by: Frank Hennick, Volunteer with the Center for Victims of Torture

Morina, N., Schnyder, U., Schick, M., Nickerson, A., & Bryant, R. A. (2016a). The Australian and New Zealand Journal of Psychiatry, 50(12), 1161–1168.

### Study Details

The connection between interpersonal traumatic experiences and one's capacity for trust and relationships is well supported. Indeed, Morina, et al., observe that refugees' high rate of PTSD is connected to the *type* of distress they experience: interpersonal trauma that erodes their sense of security and trust. Interpersonal traumas include torture, combat experience, brainwashing, sexual assault, kidnapping, and forced separation, among many others. (Non-interpersonal traumas, by contrast, include natural disasters, life-threatening illness, and lack of food/water). This study analyzed such traumas, aiming to shed light on "insecure attachment tendencies" that can lead victims to cope in one or both of the following ways:

- *Avoidant* attachment tendencies, whereby an individual seeks distance from attachment figures.
- *Anxious* attachment tendencies, in which trauma survivors "hyperactivate their attachment needs".

The study hypothesized that a victim's attachment dysfunctions would correlate to the *degree* of interpersonal trauma they experienced; that is, the severity and amount of traumas would be measurably evident in attachment anxiety/avoidance symptoms. The authors projected no association, however, between attachment tendencies and *non-interpersonal* traumas.

### Study Sample, Method

The research team drew its data from a 2012-13 study of refugees receiving treatment for a range of "trauma-related mental health problems." Of the 152 patients eligible for participation, 134 consented to and completed the study, a one to two hour therapist-assisted questionnaire. Traumatic events were measured according to two combined scales, the Harvard Trauma Questionnaire and the Posttraumatic Diagnostic Scale, and this served to differentiate interpersonal from non-interpersonal traumatic events. The research paper emphasizes participants' diversity, both in terms of background and experiences. All participants were aged 18 years and older with a mean age of 42.4 years old. 78 percent were men, with a mean age of 42.4 years old. All had experienced war and/or torture; 85 percent had been tortured; more than 75 percent imprisoned, forcibly isolated, and/or assaulted. There was a mean of 13.23 different types of trauma experienced per patient. Patient nationalities included Turkey, Iran, Bosnia, Sri Lanka, and Iraq, among others.

### Study Findings

As hypothesized, the study confirmed a strong association between interpersonal traumas and avoidant attachment behaviors. As expected, no such connection was found between interpersonal traumas and *anxious* attachment behaviors, and non-interpersonal traumas did not predict either attachment tendency. The authors were surprised to find no connection between the patients' refugee experiences and *anxious* attachment tendencies. This, Dr. Morina suggests, may owe to the very nature of these experiences: such traumas breed great distrustfulness and reluctance to embrace others.

The paper proposes that the nature of these traumas—often involving the severance of close personal bonds—erodes one's ability to trust and spawns avoidant tendencies. The study advises that the damage of interpersonal traumas be considered cumulatively, and avoidant tendencies are likely exacerbated in times of stress. The patients in this study sample, the paper notes, are especially vulnerable to such avoidant tendencies, given their ongoing posttraumatic stress symptoms. The study further concludes that such patients are less likely to benefit



from supportive attachment figures, if they do indeed connect with them. As such, they are at risk for further psychological damage over time, as their posttraumatic stresses take a toll.

### **Limitations**

The paper notes several significant limitations to the research project. These included that the impact of culture on “construct of attachment” has not been adequately considered. In addition, all study participants were in treatment; there was no examination of trauma victims in need. Men were also overrepresented, comprising 78% of the sample. Lastly, childhood attachment was not accounted for.

### **Conclusions**

Dr. Morina and his team depict their study as an initial step toward a fuller understanding of attachment tendencies among victims of interpersonal trauma. Although the study’s findings were largely speculative and drawn from a small sample, the authors advise that its results warrant a wider and deeper examination. Gender, for instance, was observed to be a predictor of avoidant tendencies, and so a study that better represents females would hopefully provide clearer insight into the role of gender. The findings further differentiate interpersonal from non-interpersonal traumas and speak to their dissimilar impacts on human psychology. Interpersonal traumas, the paper verifies, have a uniquely powerful association with attachment tendencies. In the end, the study clarifies existing scholarship, while suggesting encouraging avenues for future study.

## **Testimonial therapy for survivors of torture in Cambodian and Sri Lankan contexts**

Combined summary of two articles by: Eden Almasude, Volunteer with The Center for Victims of Torture

Puvimanasinghe, T. S. & Price, I. R. (2016). Healing through giving testimony: An empirical study with Sri Lankan torture survivors. *Transcultural Psychiatry*, 53(5), 531–550.

Esala, J.J. & Taing, S. (2017). Testimony therapy with ritual: A pilot randomized controlled trial. *Journal of Traumatic Stress*. 30 (1): 1 – 5.

### **Study Details**

Testimony therapy addresses the personal and societal impacts of political violence through narrative storytelling and documentation of traumatic events. It was first developed in 1970s Chile and has since been adapted to many different cultural contexts. In each context, the approach must be specifically based in the spiritual beliefs, rituals, and political traumas of the group of survivors. Testimonial therapy often involves a component of editing and publishing the survivors’ stories, which serves as a form of truth-telling and societal healing. Another benefit of this approach is that it is generally low-cost, brief, and culturally specific. However, the effectiveness of the method did not have high-quality evidence from randomized controlled trials.

These two studies attempt to address this limitation in scholarship on testimonial therapy. They do so by presenting findings from recent randomized experimental trials evaluating the outcomes of testimonial therapy versus a control group with no treatment. One trial took place in Cambodia (Esala & Taing, 2017); the other took place in Sri Lanka (Puvimanasighe & Price, 2016).

### **Study Samples**

The specifics of each form of testimonial therapy were distinct, given the different cultural and political backgrounds of survivors. In the Cambodian context, this was a four day process of individual counseling, including narrative story-telling and later publication, followed by a Buddhist ceremony at the Khmer Rouge Killing Fields



and a truth-telling event with invited community members. The Sri Lankan approach involved four sessions of narration, editing, and re-reading the testimony, followed by a ceremony of lamp-lighting and a communal meal with family members and other survivors of torture.

### **Study Findings**

The statistical analysis and outcome measures of the studies also differed. In the Cambodian study, a blinded investigator assessed symptoms of post-traumatic stress disorder (PTSD), anxiety, and depression at baseline, as well as three and six months after the testimony therapy. They found significant changes ( $p \leq 0.001$ ) across all three measures from baseline to three months, but no significant changes between three and six months. The Sri Lankan study evaluated the Sri Lanka Index of Psychosocial Status (SLIPSS-A), a scale of community participation, and the World Health Organization Five Well-being Index (WHO-5). Significant improvement ( $p \leq 0.05$ ) was found in the SLIPSS-A, but not the participation scale or WHO-5 measures. This study also included a qualitative analysis which noted four primary themes across survivor interviews: story coherence, emotional expression, coping strategies, and future aspirations. All participants identified the testimonial ceremony as a “turning point” in their recovery, emphasizing the importance of witnessed storytelling and honor.

### **Study Conclusions**

Both studies showed positive evidence for the use of testimonial therapy as a culturally-relevant and low-resource approach to torture rehabilitation. At the same time, both share a limitation. In both studies, the control group was placed on a “waitlist” for treatment; providing a negative control, however, does not allow either study to demonstrate an improved benefit of testimonial therapy as compared to other existing treatment approaches. Even so, these preliminary data, collected in different cultural context, support using forms of testimonial therapy in treating trauma-related symptoms.

## **The Factor Structure of Complex Posttraumatic Stress Disorder in Traumatized Refugees**

Nickerson, A., Cloitre, M., Bryant, R. A., Schnyder, U., Morina, N., & Schick, M. (2016). The factor structure of complex posttraumatic stress disorder in traumatized refugees. *European Journal of Psychotraumatology*, 7.

Summary by: Ann Zedginidze, Volunteer with the Center for Victims of Torture

### **Study Details**

The concept of complex posttraumatic stress disorder (CPTSD) is used in the International Classification of Diseases and Related Health Problems (ICD-11). It is considered a “sibling” diagnoses to post traumatic stress disorder (PTSD). CPTSD is not a classification in the *Diagnosics and Statistical Manual 5th Edition*; it was excluded because some believe the symptoms of CPTSD are covered within the PTSD requirements. According to the ICD-11, the differential diagnosis of PTSD versus CPTSD is marked by the presence of disturbance in self-organization (DSO). If an individual endorses symptoms of DSO they indicated impairment in affective regulation, self-concept, and interpersonal relationships. CPTSD is diagnosed when trauma survivors meet PTSD requirements and endorse at least one of two possible symptoms in the categories of affective regulation, self-concept and interpersonal relationships (DSO). It has been argued that in addition to the PTSD symptoms, DSO symptoms present more detrimental changes in the survival’s ability to function.

CPTSD is especially likely to occur after exposure to repeated, prolonged, interpersonal trauma exposure. These symptoms were originally formulated to describe the psychological effects of torture, or individuals exposed to a sustained and coerced environment. CPTSD is examined within refugee populations who are displaced, as they are



likely to experience mass trauma, persecution and torture. The object of this study was to examine the structure of CPTSD diagnosis and the classification of symptoms.

### **Study Sample**

The study consisted of 134 refugees and asylum seekers who were receiving mental health treatment at an outpatient unit for victims in Zurich or Berns, Switzerland. Participants had to be age 18 or older. They also had to speak German, English, Turkish, Arabic, Farsi or Tamil. The study sample had a mean age of 42.4 years and 78 percent of the participants were male. Participants had been exposed to an average of 13.11 types of traumatic events, with over 90 percent of the sample having experienced torture. Other commonly reported traumas included enforced isolation from others, imprisonment, non-sexual assault by a stranger, combat situation, being close to death, and murder of a family member or a friend. Participants who were not able to use the tablet-based software, were pregnant, exhibited dissociative, psychosis or suicide symptoms were excluded from the study.

The assessments specifically designed for this study measure CPTSD, PTSD, and DSO. Questionnaires measured CPTSD categorized into six lower-order factors (re-experiencing, avoidance, arousal, affective dysregulation, disturbances in self-concept, and disrupted interpersonal relations). The two-factor model consisted of questionnaires for PTSD (re-experiencing, avoidance, and arousal) and DSO (affective dysregulation, disturbances in self-concept, and disruptions in interpersonal relations).

### **Study Findings**

Findings revealed that a two-factor, higher-order model comprising of PTSD and DSO was a better fit compared to a one-factor higher-order model of CPTSD. In other words, when CPTSD is categorized as PTSD and DSO as separate, but correlated factors, it becomes a better fit in encompassing the disorder. This study evaluated the factor structure for the proposed ICD-11 diagnosis for CPTSD. The study found that two-factor higher-order solution had the best model fit, meaning the diagnostic criteria for PTSD and DSO are distinct but related in nature. Measuring symptoms of CPTSD with six lower-order factors was not a better fit in comparison to PTSD and DSO distinctly.

### **Conclusion**

This study can help us understand the psychopathology of trauma and most appropriate ways to classify the diagnosis. Measuring symptoms PTSD and DSO distinctly can help us understand best ways to differentiate, diagnose and treat people who have been exposed to extreme human rights violations.

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## Additional Relevant Resources

- Dignity (The Danish Institute Against Torture) provides a database that allows you to search for a wider range of articles, books, and other publications on the topic of torture (<http://www.reindex.org/RCT/rss/Portal.php>).
- IRCT (International Rehabilitation Council for Torture Victims) provides free access to their journal, *TORTURE Journal* (<http://www.irct.org/media-and-resources/library/torture-journal.aspx>).