



# The National Center for Post-Traumatic Stress Disorder PTSD RESEARCH QUARTERLY

VOLUME 15, NUMBER 2

ISSN 1050-1835

SPRING 2004

## EMOTIONAL REACTIONS TO TORTURE AND ORGANIZED STATE VIOLENCE

Stuart Turner, MD  
*University College, London, UK*

Torture is “any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him..., or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity...” (Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, UN General Assembly, 1984, [http://www.unhcr.ch/html/menu3/b/h\\_cat39.htm](http://www.unhcr.ch/html/menu3/b/h_cat39.htm)).

Torture has been in use for a very long time, but its nature and purpose has changed—probably in the 20<sup>th</sup> century. In the modern world, torture is typically used covertly and extra-judicially as part of a process of state-sponsored violence against minority ethnic, religious, or other communities. It is a means used systematically by many states to terrorize some of their own people and communities.

From a social and cultural perspective, context is as important as the experience itself. States that use torture need to make sure that those at risk (either because of their actions or by virtue of belonging to a particular group) are fully aware of this. On the other hand, the rest of the population needs to be kept in ignorance as much as possible; it is a covert, deniable activity. In addition, the use of soldiers (or paramilitary and non-state militias) to round up people, the enforced displacement of communities (including ethnic cleansing), and policies of detention for particular communities all take on a larger meaning in the context of torture. These broader activities go beyond the UN definition but provide a related backdrop of fear and intimidation. In this article, a broad approach will be adopted to consider torture and other forms of organized state violence.

*Epidemiology.* Torture is not an easy phenomenon to investigate because it is covert and routinely denied. We do not know how many victims survive. In countries where torture is widespread, it is usually unsafe to undertake research in this area. More work has been done with refugee communities, which include survivors of torture and other forms of state-sponsored violence.

However, refugees are a distinct group. Migration and post-migration factors contribute significantly to their emotional burden. Steel et al. (1999) in Australia studied Tamil asylum-seekers, refugees, and immigrants. Although pre-migration stress contributed to 20% of the variance of posttraumatic stress symptoms, post-migration stress contributed an additional 14% of the variance. Gorst-Unsworth and Goldenberg (1998) interviewed 84 male Iraqi refugees in London and found that the level of social support in exile was important in relation to both PTSD and Major Depressive Disorder (MDD). Poor (current) social support was a stronger predictor of depressive morbidity than (past) trauma factors. Turner et al. (2003) compared a large Kosovan refugee sample in the United Kingdom with another large sample studied in Kosovo at around the same time (Lopes Cardozo et al., 2000). Those in Kosovo were more likely to experience anxiety/insomnia and somatic symptoms; those in the UK had higher social dysfunction and severe depression.

Torture is a complex experience, and its effects are also complex. Why should the reaction of someone who has witnessed the extra-judicial killing of a daughter in detention be the same as someone who has been beaten, humiliated, and raped? Why should the response of people from different cultural settings be the same? In 1990, Turner and Gorst-Unsworth published a review paper highlighting four common themes in this complex picture—PTSD as a result of specific torture experiences; depression as a result of consequential losses; somatization phenomena where physical violence was used for psychological effect; and the “existential dilemma” of surviving in a world in which torture had been shown to be a hard reality.

Redress ([www.redress.org](http://www.redress.org)) is an internationally focused non-profit human rights/legal organization, based in London, that helps torture survivors obtain justice and reparation.

Eitinger (1964), following the Holocaust, distinguished between immediate trauma and the tearing-up of a whole social world, leaving many survivors without any form of “anchorage in the world.” Certainly there is a lot more to this than just the disorder we now call PTSD. We still lack a good research-based description of these long-term (existential) consequences experienced by some survivors of torture. The ICD-10 diagnosis of Enduring Personality Change after Catastrophic Experience is probably the best available, but this is

Author’s Address: 7 Devonshire Street, London, W1W5DY, UK.  
Email Address: [S.Turner@traumaclicnic.org.uk](mailto:S.Turner@traumaclicnic.org.uk)

Published by:

The National Center for PTSD  
VA Medical and Regional  
Office Center (116D)  
215 North Main Street  
White River Junction  
Vermont 05009-0001 USA

☎ (802) 296-5132  
FAX (802) 296-5135

Email: [ptsd@dartmouth.edu](mailto:ptsd@dartmouth.edu)  
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an area that deserves much more work—especially taking account of the impact of cultural and religious diversities.

Perhaps because PTSD and MDD are relatively easy to measure, they have been the focus of epidemiological research. In a community study of 993 Cambodian adult refugees in a camp on the Thai border, 55% were estimated to have MDD and 15% PTSD (Mollica et al., 1993). A dose-response relationship was found between trauma history and symptom categories of depression, PTSD, dissociation, and culturally dependent symptoms (Mollica et al., 1998). Using similar measures in a group of 534 Bosnian refugees living in Croatia, 39% were estimated to have MDD, and 26% PTSD (with a substantial overlap). Those with co-morbid MDD and PTSD were more likely to have a disability, as were those of older age, with cumulative trauma histories or with chronic medical illness (Mollica et al., 1999). In a three-year follow-up study of this Bosnian group (Mollica et al., 2001), 45% of those who had earlier met criteria for MDD, PTSD, or both continued to have these disorders and a further 16%, previously asymptomatic, had developed one or both of these conditions.

Some caution is required in interpreting epidemiological evidence based on self-report measures. Turner et al. (2003), in a large survey of 842 adult Kosovan refugees in the United Kingdom, included interviews in a subset of participants; they found that self-report measures tended to overestimate the prevalence of PTSD. Silove et al. (2000) have emphasized the importance of achieving an accurate and balanced position: "Disagreement among experts in the field seems to stem mainly from an 'either-or' fallacy, with some authorities implying that entire populations exposed to war are 'traumatized'" (p. 1548).

In a population-based interview study of the long-term effects of trauma, Steel et al. (2002) investigated a community sample in Australia of 1413 Vietnamese adults, 82% completing the interview. There was a mean length of residence in Australia of 11.2 years, and the mean time since the most severe traumatic event was 14.8 years. As expected, given the timescale, rates of psychiatric disorder in this long-term refugee population were much lower (7-8%), but even so, trauma exposure was found to be the most important predictor of mental health status.

In war-affected Tamil refugees and immigrants in Australia, Silove et al. (2002) found that those exposed to torture returned higher PTSD scores than other war trauma survivors after controlling for overall levels of trauma exposure, suggesting that torture is a particularly traumatic experience. Mollica et al. (2002) have highlighted the clinical importance of head injury as a specific aspect of torture and mass violence. On the other hand, in a comparison of 418 tortured and 392 non-tortured Bhutanese refugees living in Nepal, overall levels of disability were found to be similar. In the tortured group, disability was associated with PTSD, specific phobia, and present physical illness; in the non-tortured group, the pattern was different, disability being associated with present physical disease, older age, and generalized anxiety disorder (Thapa et al., 2003). Coping mechanisms and social support have

been identified as important factors in this non-Western setting (Emmelkamp et al., 2002). In a larger interview study comparing 526 tortured and 526 nontortured Bhutanese refugees, the number of PTSD symptoms (independent of depression and anxiety) predicted somatic complaints, emphasizing the need to screen for PTSD even when people present with somatic symptoms (Van Ommeren et al., 2002).

De Jong et al. (2001) studied community samples in four low-income countries that had recently been experiencing internal conflict. The prevalence rates for PTSD were 37.4% in Algeria, 28.4% in Cambodia, 15.8% in Ethiopia, and 17.8% in Gaza. Torture was reported by 8.4% in Algeria, 9.0% in Cambodia, 25.5% in Ethiopia, and 15.0% in Gaza. In all cases, torture was significantly related to risk of PTSD. This study is important as it looked at people in their own countries and allows some cross-cultural comparisons.

In summary, this epidemiological evidence may be taken as indicating that torture, along with other forms of low-grade warfare and organized violence, causes emotional problems in some people and that these problems may persist over long periods of time. However, the reverse of this is that substantial numbers of people survive these experiences without developing any psychiatric disorder—a testimony to the resilience of the human mind.

Basoglu et al. (1997) have compared tortured political activists and tortured non-activists, studied in their own country. The non-activists had less severe torture but greater post-torture psychopathology. Preparation for torture was a protective factor. Holtz (1998) in a comparison study also found that prior knowledge and preparation for confinement and torture was protective.

*Interventions.* The main deficiency in the literature is to do with the effect of intervention. This is made more complex because of the many needs with which people present. A phased model of intervention is likely to be required, focusing on safety and trust before undertaking therapeutic work.

For those who have left their countries in fear of persecution, it may seem perverse that the first thing we expect is that they will disclose their most disturbing experiences to state officials in order to achieve safety. Yet this is the situation in countries that review individual asylum applications. Where there is a history of rape, it is usual to find high levels of shame and avoidance (Van Velsen et al., 1996), and late disclosure is common. Unfortunately, people who change their stories are often accused of lying and denied safety. Indeed, empirical evidence into traumatic memory now highlights the fallacy of attaching too much importance to discrepant recollection (Herlihy et al., 2002).

One technique with a long track record in this area is called Testimony. It involves the construction of a narrative, a detailed account of the torture, involving reframing of some of these experiences. It therefore includes elements that might be understandable as exposure or cognitive therapy. However, it also takes account of the political and social meanings of the experience, and this makes it a more acceptable approach for many survivors. Weine et al.

(1998) set out the approach in some detail in an open study of Bosnian refugees in the USA.

As long as the intervention is culturally acceptable, there is no a priori reason to believe that standard interventions are inappropriate. For example, Paunovic and Öst (2001) compared exposure therapy and CBT in the treatment of PTSD in refugees. Both groups improved, with no differences between these approaches.

Political and social change may also be needed. In the aftermath of large-scale repression and conflict, there may be a key role for national reconciliation programs such as the Truth and Reconciliation Commission in South Africa. Whether or not this helps individuals in their recovery, it does acknowledge the need for acknowledgment, apology, and reparation.

Most torture survivors will not present in western countries. Some will need sustainable and accessible services, often in dangerous settings. One model has involved the establishment of a network of rehabilitation services (Modvig & Jørgensen, 2003) with strong central support. ISTSS has sponsored the development of a set of international training guidelines (Weine et al., 2002), recognizing that simply parachuting in so-called experts to conflict zones does not always allow the development of culturally sensitive or sustainable service development.

## SELECTED ABSTRACTS

BASOGLU, M., MINEKA, S., PAKER, M., AKER, T., LIVANOU, M., & GÖK, S. (1997). **Psychological preparedness for trauma as a protective factor in survivors of torture.** *Psychological Medicine*, 27, 1421-1433. *Background:* Although much research has focused on mechanisms of traumatization and factors related to post-trauma psychological functioning in survivors of trauma, there have been few studies of survivors of torture despite the widespread practice of torture in the world. The aim of this study was to examine the role of 'psychological preparedness' for trauma in post-traumatic stress responses in survivors of torture. *Method:* 34 torture survivors who had no history of political activity, commitment to a political cause or group, or expectations of arrest and torture were compared with 55 tortured political activists, using structured interviews and measures of anxiety, depression, and PTSD. *Results:* Compared with tortured political activists, tortured non-activists were subject to relatively less severe torture but showed higher levels of psychopathology. Less psychological preparedness related to greater perceived distress during torture and more severe psychological problems, explaining 4% of the variance in general psychopathology and 9% of the variance in PTSD symptoms. *Conclusions:* The study findings lend support to the role of prior immunization to traumatic stress and to unpredictability and uncontrollability of stressors in the effects of traumatization. Further research aimed at identifying the behavioural and cognitive components of psychological preparedness that play a role in traumatization may provide useful insights into effective treatment strategies for survivors of torture.

DE JONG, J.T.V.M., KOMPROE, I.H., VAN OMMEREN, M., EL MASRI, M., ARAYA, M., KHALED, N., VAN DE PUT, W.A.C.M., & SOMASUNDARAM, D.J. (2001). **Lifetime events and posttraumatic stress disorder in 4 postconflict settings.**

*Journal of the American Medical Association*, 286, 555-562. *Context:* Little is known about the impact of trauma in postconflict, low-income countries where people have survived multiple traumatic experiences. *Objective:* To establish the prevalence rates of and risk factors for PTSD in 4 postconflict, low-income countries. *Design, Setting, and Participants:* Epidemiological survey conducted between 1997 and 1999 among survivors of war or mass violence (aged  $\geq 16$  years) who were randomly selected from community populations in Algeria ( $n = 653$ ), Cambodia ( $n = 610$ ), Ethiopia ( $n = 1200$ ), and Gaza ( $n = 585$ ). *Main Outcome Measure:* Prevalence rates of PTSD, assessed using the PTSD module of the Composite International Diagnostic Interview version 2.1 and evaluated in relation to traumatic events, assessed using an adapted version of the Life Events and Social History Questionnaire. **RESULTS:** The prevalence rate of assessed PTSD was 37.4% in Algeria, 28.4% in Cambodia, 15.8% in Ethiopia, and 17.8% in Gaza. Conflict-related trauma after age 12 years was the only risk factor for PTSD that was present in all 4 samples. Torture was a risk factor in all samples except Cambodia. Psychiatric history and current illness were risk factors in Cambodia (adjusted odds ratio [OR], 3.6; 95% confidence interval [CI], 2.3-5.4 and adjusted OR, 1.6; 95% CI, 1.0-2.7, respectively) and Ethiopia (adjusted OR, 3.9; 95% CI, 2.0-7.4 and adjusted OR, 1.8; 95% CI, 1.1-2.7, respectively). Poor quality of camp was associated with PTSD in Algeria (adjusted OR, 1.8; 95% CI, 1.3-2.5) and in Gaza (adjusted OR, 1.7; 95% CI, 1.1-2.8). Daily hassles were associated with PTSD in Algeria (adjusted OR, 1.6; 95% CI, 1.1-2.4). Youth domestic stress, death or separation in the family, and alcohol abuse in parents were associated with PTSD in Cambodia (adjusted OR, 1.7; 95% CI, 1.1-2.6; adjusted OR, 1.7; 95% CI, 1.0-2.8; and adjusted OR, 2.2; 95% CI, 1.1-4.4, respectively). *Conclusions:* Using the same assessment methods, a wide range of rates of symptoms of PTSD were found among 4 low-income populations who have experienced war, conflict, or mass violence. We identified specific patterns of risk factors per country. Our findings indicate the importance of contextual differences in the study of traumatic stress and human rights violations.

EMMELKAMP, J., KOMPROE, I.H., VAN OMMEREN, M., & SCHAGEN, S. (2002). **The relation between coping, social support and psychological and somatic symptoms among torture survivors in Nepal.** *Psychological Medicine*, 32, 1465-1470. *Background:* Little is known about the relation between coping, social support, and psychological and somatic symptoms among survivors of torture living outside the West. *Method:* In a population-based dataset of 315 tortured Bhutanese refugees, univariate and multivariate relationships between coping and social support and symptoms were estimated. These relationships were verified in a second sample of 57 help-seeking Nepalese torture survivors. *Results:* A relationship was observed between the total number of coping strategies used and anxiety and depression. Negative coping, in contrast to positive coping, was related to all symptom outcome measures. Received social support was stronger related to symptoms than perceived social support. The findings from the first sample were replicated in the second sample. *Conclusion:* We found hypothesized relationships between coping, social support, and psychological and somatic symptoms among survivors of torture living in Nepal. The findings from this study confirm the importance of understanding specific types of coping and social support to develop intervention programmes for torture survivors in Non-western settings.

GORST-UNSWORTH, C., & GOLDENBERG, E. (1998). **Psychological sequelae of torture and organised violence suffered**

**by refugees from Iraq: Trauma-related factors compared with social factors in exile.** *British Journal of Psychiatry*, 172, 90-94. *Background:* Refugees who have suffered traumatic events present complex therapeutic challenges to health professionals. There is little research into post-exile factors that may be amenable to change, and therefore reduce morbidity. We examined the importance of social factors in exile and of trauma factors in producing the different elements of psychological sequelae of severe trauma. *Method:* 84 male Iraqi refugees were interviewed. Adverse events and level of social support were measured. Various measures of psychological morbidity were applied, all of which have been used in previous trauma research. *Results:* Social factors in exile, particularly the level of 'affective' social support, proved important in determining the severity of both PTSD and depressive reactions, particularly when combined with a severe level of trauma/torture. Poor social support is a stronger predictor of depressive morbidity than trauma factors. *Conclusions:* Some of the most important factors in producing psychological morbidity in refugees may be alleviated by planned, integrated rehabilitation programmes and attention to social support and family reunion.

HERLIHY, J., SCRAGG, P., & TURNER, S.W. (2002). **Discrepancies in autobiographical memories — implications for the assessment of asylum seekers: Repeated interviews study.** *British Medical Journal*, 324, 324-327. *Objective:* To investigate the consistency of autobiographical memory of people seeking asylum, in light of the assumption that discrepancies in asylum seekers' accounts of persecution mean that they are fabricating their stories. *Design:* Repeated interviews. *Setting:* England, 1999 and 2000. *Participants:* Community sample of 27 Kosovan and 12 Bosnian refugees. *Main Outcome Measures:* Discrepancies in repeated descriptions of one traumatic and one non-traumatic event, including specific details, rated as central or peripheral to the event. Self report measures of PTSD and depression. *Results:* Discrepancies between an individual's accounts were common. For participants with high levels of post-traumatic stress, the number of discrepancies increased with length of time between interviews. More discrepancies occurred in details peripheral to the account than in details that were central to the account. *Conclusion:* The assumption that inconsistency of recall means that accounts have poor credibility is questionable. Discrepancies are likely to occur in repeated interviews. For refugees showing symptoms of high levels of post-traumatic stress, the length of the application process may also affect the number of discrepancies. Recall of details rated by the interviewee as peripheral to the account is more likely to be inconsistent than recall of details that are central to the account. Thus, such inconsistencies should not be relied on as indicating a lack of credibility.

LOPESCARDOZO, B., VERGARA, A., AGANI, F., & GOTWAY, C.A. (2000). **Mental health, social functioning, and attitudes of Kosovar Albanians following the war in Kosovo.** *Journal of the American Medical Association*, 284, 569-577. *Context:* The 1998-1999 war in Kosovo had a direct impact on large numbers of civilians. The mental health consequences of the conflict are not known. *Objectives:* To establish the prevalence of psychiatric morbidity associated with the war in Kosovo, to assess social functioning, and to identify vulnerable populations among ethnic Albanians in Kosovo. *Design, Setting, and Participants:* Cross-sectional cluster sample survey conducted from August to October 1999 among 1358 Kosovar Albanians aged 15 years or older in 558 randomly selected households across Kosovo. *Main Outcome Measures:* Nonspecific psychiatric morbidity, PTSD symptoms, and social

functioning using the General Health Questionnaire 28 (GHQ-28), Harvard Trauma Questionnaire, and the Medical Outcomes Study Short-Form 20 (MOS-20), respectively; feelings of hatred and a desire for revenge among persons surveyed as addressed by additional questions. *Results:* Of the respondents, 17.1% (95% confidence interval [CI], 13.2-21.0%) reported symptoms that met DSM-IV criteria for PTSD; total mean score on the GHQ-28 was 11.1 (95% CI, 9.9-12.4). Respondents reported a high prevalence of traumatic events. There was a significant linear decrease in mental health status and social functioning with increasing amount of traumatic events ( $P \leq .02$  for all 3 survey tools). Populations at increased risk for psychiatric morbidity as measured by GHQ-28 scores were those aged 65 years or older ( $P = .006$ ), those with previous psychiatric illnesses or chronic health conditions ( $P < .001$  for both), and those who had been internally displaced ( $P = .009$ ). Populations at risk for poorer social functioning were living in rural areas ( $P = .001$ ), were unemployed ( $P = .046$ ) or had a chronic illness ( $P = .01$ ). Respondents scored highest on the physical functioning and role functioning subscales of the MOS-20 and lowest on the mental health and social functioning subscales. 89% of men and 90% of women reported having strong feelings of hatred toward Serbs. 51% of men and 43% of women reported strong feelings of revenge; 44% of men and 33% of women stated that they would act on these feelings. *Conclusions:* Mental health problems and impaired social functioning related to the recent war are important issues that need to be addressed to return the Kosovo region to a stable and productive environment.

MOLLICA, R.F., MCINNES, K., POOLE, C., & TOR, S. (1998). **Dose-effect relationships of trauma to symptoms of depression and post-traumatic stress disorder among Cambodian survivors of mass violence.** *British Journal of Psychiatry*, 17, 482-488. *Background:* The dose-effect relationships of cumulative trauma to the psychiatric symptoms of major depression and PTSD in a community study of Cambodian survivors of mass violence were evaluated. *Method:* In 1990, a survey of 1000 households was conducted in a Thai refugee camp (Site 2) using a multi-stage random sampling design. Trauma history and psychiatric symptoms were assessed for two time periods. Analysis used linear dose-response regression modelling. *Results:* 993 Cambodian adults reported a mean of 14 Pol Pot era trauma events and 1.3 trauma events during the past year. Symptom categories of depression, PTSD, dissociative and culturally dependent symptoms exhibited strong dose-effect responses with the exception of avoidance. All symptom categories, except avoidant symptoms, were highly correlated. *Conclusions:* Cumulative trauma continued to affect psychiatric symptom levels a decade after the original trauma events. The diagnostic validity of PTSD criteria, with the notable exception of avoidance, was supported. Inclusion of dissociative and culturally dependent symptoms increased the cultural sensitivity of PTSD.

MOLLICA, R.F., MCINNES, K., SARAJLIC, N., LAVELLE, J., SARAJLIC, I., & MASSAGLI, M.P. (1999). **Disability associated with psychiatric comorbidity and health status in Bosnian refugees living in Croatia.** *Journal of the American Medical Association*, 282, 433-439. *Context:* The relationship between psychiatric symptoms and disability in refugee survivors of mass violence is not known. *Objective:* To determine if risk factors, such as demographics, trauma, health status, and psychiatric illness, are associated with disability in Bosnian refugees. *Design, Setting, and Participants:* Cross-sectional survey conducted in 1996 of Bosnian refugee adults living in a camp established by the Croatian

government near the city of Varazdin. One adult aged 18 years or older was randomly selected from each of 573 camp families; 534 (93%) agreed to participate (mean age, 50 years; 41% male). *Main Outcome Measures:* Culturally validated measures for depression and PTSD included the Hopkins Symptom Checklist 25 and the Harvard Trauma Questionnaire, respectively. Disability measures included the Medical Outcomes Study Short-Form 20, a physical functioning scale based on World Health Organization criteria, and self-reports of socioeconomic activity, levels of physical energy, and perceived health status. *Results:* Respondents reported a mean (SD) of 6.5 (4.7) unduplicated trauma events; 18% ( $n=95$ ) had experienced 1 or more torture events. While 55.2% reported no psychiatric symptoms, 39.2% and 26.3% reported symptoms that meet DSM-IV criteria for depression and PTSD, respectively; 20.6% reported symptoms comorbid for both disorders. A total of 25.5% reported having a disability. Refugees who reported symptoms comorbid for both depression and PTSD were associated with an increased risk for disability compared with asymptomatic refugees (unadjusted odds ratio [OR], 5.02; 95% confidence interval [CI], 3.05-8.26; adjusted OR, 2.06; 95% CI, 1.10-3.86). Older age, cumulative trauma, and chronic medical illness were also associated with disability. *Conclusions:* In a population of Bosnian refugees who had recently fled from the war in Bosnia and Herzegovina, psychiatric comorbidity was associated with disability independent of the effects of age, trauma, and health status.

PAUNOVIC, N., & ÖST, L-G. (2001). **Cognitive-behavior therapy vs exposure therapy in the treatment of PTSD in refugees.** *Behaviour Research and Therapy*, 39, 1183-1197. The present study investigated the efficacy of cognitive-behavior therapy (CBT) and exposure therapy (E) in the treatment of PTSD in refugees. 16 outpatients fulfilling the DSM-IV criteria for PTSD were randomized to one of the two treatments. Assessor and self-report measures of PTSD-symptoms, generalized anxiety, depression, quality of life and cognitive schemas were administered before and after treatment, and at a 6-month follow-up. The patients were treated individually for 16-20 weekly sessions. The results showed that both treatments resulted in large improvements on all the measures, which were maintained at the follow-up. There was no difference between E and CBT on any measure. E and CBT led to a 48 and 53% reduction on PTSD-symptoms, respectively, a 49 and 50% reduction on generalized anxiety, and a 54 and 57% reduction on depression. The results were maintained at the 6-month follow-up. The conclusion that can be drawn is that both E and CBT can be effective treatments for PTSD in refugees.

SILOVE, D.M., STEEL, Z., MCGORRY, P.D., MILES, V., & DROBNY, J. (2002). **The impact of torture on post-traumatic stress symptoms in war-affected Tamil refugees and immigrants.** *Comprehensive Psychiatry*, 43, 49-55. The present study examines the effect of torture in generating PTSD symptoms by comparing its impact with that of other traumas suffered by a war-affected sample of Tamils living in Australia. Traumatic predictors of PTSD were examined among a subsample of 107 Tamils (refugees, asylum seekers, and voluntary immigrants) who had endorsed at least one trauma category on the Harvard Trauma Questionnaire. Principal components analysis (PCA) yielded five trauma factors that were applied to predicting PTSD scores. Tamils exposed to torture returned statistically higher PTSD scores than other war trauma survivors after controlling for overall levels of trauma exposure. The torture factor identified by the PCA was found to be the main predictor of PTSD in a multiple

regression analysis. Although limited by sampling constraints and retrospective measurement, the present study provides support for the identification of torture as a particularly traumatic event, even when the impact of other war-related trauma is taken into account.

STEEL, Z., SILOVE, D.M., BIRD, K., MCGORRY, P.D., & MOHAN, P. (1999). **Pathways from war trauma to posttraumatic stress symptoms among Tamil asylum seekers, refugees, and immigrants.** *Journal of Traumatic Stress*, 12, 421-435. Path analysis was used to examine the antecedents of posttraumatic stress (PTS) symptoms in Tamil asylum-seekers, refugees, and immigrants in Australia. The Harvard Trauma Questionnaire and a postmigration living difficulties questionnaire were completed by 62 asylum-seekers, 30 refugees, and 104 immigrants who responded to a mail-out. Demographic characteristics, residency status, and measures of trauma and postmigration stress were fitted to a structural model in PTS symptoms. Premigration trauma exposure accounted for 20% of the variance of PTS symptoms. Postmigration stress contributed 14% of the variance. Although limited by sampling constraints and retrospective measurement, the study supports the notion that both traumatic and posttraumatic events contribute to the expression of PTS symptoms.

STEEL, Z., SILOVE, D.M., PHAN, T., & BAUMAN, A. (2002). **Long-term effect of psychological trauma on the mental health of Vietnamese refugees resettled in Australia: A population-based study.** *Lancet*, 360, 1056-1062. *Background:* What are the deleterious effects of mass trauma on the psychological wellbeing of refugees and other war-affected populations? Most epidemiological data are for short-to-medium term effects, leaving the possibility that early psychological reactions could reduce naturally over time. We aimed to assess the long-term effects of trauma on mental health and disability in Vietnamese refugees resettled in Australia. *Methods:* In a population-based study, we identified a community sample of 1413 adult Vietnamese from census collection areas in Sydney, Australia. Participants were interviewed by trained bilingual workers who administered questionnaires to assess the frequency of ICD-10 mental disorders in the 12 months before interview; psychiatric symptoms, by use of a culturally-sensitive symptom measure; exposure to psychologically traumatic events; disability and use of health services; and social, economic, and cultural factors since migration. We did multivariate analyses with adjustment for stressors since migration to establish the risk factors for mental illness. *Findings:* 1161 (82%) adults completed the interview. Mean length of residence in Australia was 11.2 years (SD 14.4) and mean time since the most severe traumatic event was 14.8 years (SD 10.8), 95 (8%) and 75 (7%) of participants had mental disorders defined by ICD-10 and the culturally sensitive measure, respectively. Trauma exposure was the most important predictor of mental health status. Risk of mental illness fell consistently across time. However, people who had been exposed to more than three trauma events (199) had heightened risk of mental illness (23, [12%]) after 10 years compared with people with no trauma exposure (13, [3%]) (odds ratio 4.7,  $p < 0.0001$ , 95% CI 2.3-9.5). *Interpretation:* Most Vietnamese refugees were free from overt mental ill health. Trauma-related mental illness seemed to reduce steadily over time, but a subgroup of people with a high degree of exposure to trauma had long-term psychiatric morbidity. Our findings support the need to develop specialised mental health services to reduce disability in refugees whose exposure to extreme trauma puts them at risk of chronic psychiatric disability.

THAPA, S.B., VAN OMMEREN, M., SHARMA, B., DE JONG, J.T.V.M., & HAUFF, E. (2003). **Psychiatric disability among tortured Bhutanese refugees in Nepal.** *American Journal of Psychiatry, 160*, 2032-2037. *Objective:* Most refugees live in low-income countries. There is a lack of data on psychiatric disability among such refugees. The authors compared psychiatric disability in tortured and nontortured Bhutanese refugees living in Nepal and examined factors associated with psychiatric disability among the tortured refugees. *Method:* A cross-sectional survey was conducted among 418 tortured and 392 nontortured Bhutanese refugees, matched for age and gender. The Composite International Diagnostic Interview, version 2.1, and the World Health Organization Short Disability Assessment Schedule were used to measure ICD-10 psychiatric disorders and disability, respectively. *Results:* Approximately one in five tortured and nontortured Bhutanese refugees were found to be disabled. PTSD, specific phobia, and present physical disease were identified as factors associated with disability among the tortured refugees. On the other hand, present physical disease, greater age, and generalized anxiety disorder were associated with disability among the nontortured group. *Conclusions:* These findings show that the tortured and nontortured refugees were equally likely to be disabled. Different sets of predictors were identified among tortured and nontortured refugees, indicating the need for comprehensive psychiatric assessment of both tortured and nontortured refugees in clinical practice.

TURNER, S.W., & GORST-UNSWORTH, C. (1990). **Psychological sequelae of torture: A descriptive model.** *British Journal of Psychiatry, 157*, 475-480. Developments in the social and clinical sciences during this century have provided the opportunity for advancement in our understanding of the long-term reactions to torture. In this paper, a framework is presented which we believe might form the basis for a nosology of reactions to torture. It has been developed from our substantial clinical experience obtained with a London-based group, the Medical Foundation for the Care of Victims of Torture. Not only are these dimensions of heuristic value, they also stand to have important implications for treatment. [Adapted from Text, p. 476]

TURNER, S.W., BOWIE, C., DUNN, G., SHAPO, L., & YULE, W. (2003). **Mental health of Kosovan Albanian refugees in the UK.** *British Journal of Psychiatry, 182*, 444-448. *Background:* In 1999 the UK received 4346 refugees from Kosovo. *AIMS:* To determine the prevalence of mental health problems in this group. *Method:* A sample of 842 adults was surveyed. All were asked to complete self-report questionnaires (translated into Kosovan Albanian). A subset of 120 participants were later interviewed in Albanian using the Clinician Administered PTSD Scale and a depression interview. *Results:* The study yielded estimates of prevalence of PTSD and depression. Self-report measures appear to overestimate the prevalence of these disorders. Just under half of the group surveyed had a diagnosis of PTSD and less than one-fifth had a major depressive disorder. *Conclusions:* These results may be taken as a sign of the resilience of many who survived this conflict but they also imply that there is still a substantial need for good health and social care in a significant proportion. Psychosocial interventions are likely to be an important part of the treatment programme.

WEINE, S.M., DANIELI, Y., SILOVE, D.M., VAN OMMEREN, M., FAIRBANK, J.A., & SAUL, J. (2002). **Guidelines for international training in mental health and psychosocial interventions for trauma exposed populations in clinical and community settings.** *Psychiatry, 65*, 156-164. *Objective:* To develop con-

sensus-based guidelines for training in mental health and psychosocial interventions for trauma-exposed populations in the international arena. *Participants:* The Task Force on International Trauma Training of the International Society for Traumatic Stress Studies. *Evidence:* The Task Force engaged in a 1-year dialogue on the practice of international training, drawing upon field experience, literature review, and consultation with key informants. *Consensus Process:* This statement was prepared on the basis of shared dialogue, consensus decision making, and a writing process involving all Task Force members. It was then disseminated for review to more than 200 professionals of more than 60 service and academic organizations. Written and oral suggestions from over 80 persons were incorporated and revisions made on the basis of consensus. *Conclusions:* The generated guidelines addresses four dimensions: (1) values, (2) contextual challenges in societies during or after conflicts, (3) core curricular elements, and (4) monitoring and evaluation. The guidelines can improve international training in mental health and psychosocial interventions for trauma-exposed populations by providing principles and strategies intended to steer those who seek informed recommendations, to generate focused debates on areas where there is as yet no broad consensus, and to stimulate research and inquiry.

WEINE, S.M., DZUBUR KULENOVIC, A., PAVKOVIC, I., & GIBBONS, R. (1998). **Testimony psychotherapy in Bosnian refugees: A pilot study.** *American Journal of Psychiatry, 155*, 1720-1726. *Objective:* The authors sought to describe the use of the testimony method of psychotherapy in a group of traumatized adult refugees from genocide in Bosnia-Herzegovina. *Method:* The subjects were 20 Bosnian refugees in Chicago who gave written informed consent to participate in a case series study of testimony psychotherapy. All subjects received testimony psychotherapy, averaging 6 sessions, approximately 90 minutes, weekly or biweekly. Subjects received standardized instruments for PTSD, depression, traumatic events, global functioning, and prior psychiatric history. The instruments were administered before treatment, at the conclusion of the treatment, and at the 2- and 6-month follow-ups. *Results:* The posttreatment assessments demonstrated significant decreases in the rate of PTSD diagnosis, PTSD symptom severity, and the severity of reexperiencing, avoidance, and hyperarousal symptom clusters. Depressive symptoms demonstrated a significant decrease, and there was a significant increase in scores on the Global Assessment of Functioning Scale. 2- month and 6-month follow-up assessments demonstrated further significant decreases in all symptoms and an increase in scores on the Global Assessment of Functioning Scale. *Conclusions:* This pilot study provides preliminary evidence that testimony psychotherapy may lead to improvements in PTSD and depressive symptoms, as well as to improvement of functioning, in survivors of state-sponsored violence.

## ADDITIONAL CITATIONS Annotated by the Editor

EITINGER, L. (1964). *Concentration camp survivors in Norway and Israel.* London: Allen & Unwin.

Examined concentration camp survivors who were residing in Norway and Israel in order to describe their long-term reactions and understand how these reactions were related to various risk factors. The author's rich clinical descriptions provide a detailed picture of Holocaust survivors roughly 15-20 years after their internment.

GERRITY, E.T., KEANE, T.M., & TUMA, F. (Eds.). (2001). *The mental health consequences of torture*. Kluwer: New York.

Includes chapters on a range of topics, including research and definitional issues, statements from torture survivors, conceptual models, torture in specific populations, and clinical, legal, and human rights issues.

GREEN, B.L., FRIEDMAN, M.J., DE JONG, J.T.V.M., SOLOMON, S.D., KEANE, T.M., FAIRBANK, J.A., DONELAN, B., & FREY-WOUTERS, E. (Eds.). (2003). *Trauma interventions in war and peace: Prevention, practice, and policy*. New York: Kluwer.

Includes chapters on a broad range of issues related to war and disaster, with a special section on torture and abuse. This book resulted from collaboration between the International Society for Traumatic Stress Studies and the United Nations.

HOLTZ, T.H. (1998). **Refugee trauma versus torture trauma: A retrospective controlled cohort study of Tibetan refugees.** *Journal of Nervous and Mental Disease*, 186, 24-34.

Compared 35 Tibetan torture survivors with 35 Tibetan controls who were not tortured. Although both groups had significant symptoms, torture survivors were more likely than controls to have elevated anxiety symptoms but were comparable in depression levels.

MAERCKER, A., BEAUDUCEL, A., & SCHÜTZWOHL, M. (2000). **Trauma severity and initial reactions as precipitating factors for posttraumatic stress symptoms and chronic dissociation in former political prisoners.** *Journal of Traumatic Stress*, 13, 651-660.

Used structural equation modeling to assess predictors of PTSD and dissociation in 98 former East-German political prisoners. Lifetime PTSD symptoms were primarily predicted by initial reactions to trauma and chronic dissociation was primarily predicted by trauma severity.

MODVIG, J., & JØRGENSEN, C.K. (2003). **The international network of rehabilitation centres for torture victims: A survey study of treatment capacity and development priorities.** *Torture*, 13, Supplementum no. 2, 7-11.

Surveyed torture rehabilitation services available at 111 centers from 65 countries to determine the centers' treatment capacity and future priorities. Whereas most centers provided mental health and medical treatment, fewer provided emergency services, legal counseling, or job training.

MOLLICA, R.F., DONELAN, K., TOR, S., LAVELLE, J., ELIAS, C., FRANKEL, M., & BLENDON, R.J. (1993). **The effect of trauma and confinement on functional health and mental health status of Cambodians living in Thailand-Cambodia border camps.** *Journal of the American Medical Association*, 270, 581-586.

Assessed the effect of trauma on 993 Cambodian refugees. Reports of the prevalence of torture declined over time, from 35.6% during the Khmer Rouge regime (1975-1979) to 7.8% during the refugee period (since 1980).

MOLLICA, R.F., POOLE, C., SON, L., MURRAY, C.C., & TOR, S. (1997). **Effects of war trauma on Cambodian refugee adolescents' functional health and mental health status.** *Journal of the American Academy of Child and Adolescent Psychiatry*, 36, 1098-1106.

Examined the relationship between war trauma and symptoms in 94 female and 88 male adolescent Cambodian refugees and

their parents. There was a dose-response relationship between amount of trauma and symptoms for the parent reports, and some relationships for child-reported outcomes.

MOLLICA, R.F., SARAJLIC, N., CHERNOFF, M., LAVELLE, J., SARAJLIC VUKOVIC, I., & MASSAGLI, M.P. (2001). **Longitudinal study of psychiatric symptoms, disability, mortality, and emigration among Bosnian refugees.** *Journal of the American Medical Association*, 286, 546-554.

Conducted a 3-year follow-up of 376 Bosnian refugees among 534 who were originally studied in a Croatian refugee camp. Psychiatric disorder (depression and/or PTSD) was chronic in over 40% of the sample, as was disability. Psychiatric disorder was associated with disability at both time points.

MOLLICA, R.F., HENDERSON, D.C., & TOR, S. (2002). **Psychiatric effects of traumatic brain injury events in Cambodian survivors of mass violence.** *British Journal of Psychiatry*, 181, 339-347.

Assessed the relationship between traumatic brain injury and psychiatric outcomes in 967 Cambodian refugees. TBI explained additional variance in psychiatric symptoms even after statistical adjustment for other types of trauma exposure.

MOMARTIN, S., SILOVE, D.M., MANICAVASAGAR, V., STEEL, Z. (2003). **Dimensions of trauma associated with posttraumatic stress disorder (PTSD) caseness, severity and functional impairment: A study of Bosnian refugees resettled in Australia.** *Social Science and Medicine*, 57, 775-781.

Conducted principal components analysis with trauma exposure data from a community sample of 126 Bosnian Muslim refugees. Four dimensions were identified: human rights violations, threat to life, traumatic loss, and dispossession and eviction. Only threat to life predicted PTSD, and there were no differences in PTSD prevalence between refugees who were and who were not exposed to human rights violations.

SILOVE, D., EKBLAD, S., & MOLLICA, R. (2000). **The rights of the severely mentally ill in post-conflict societies.** *Lancet*, 355, 1548-1549.

Argues that the needs of individuals with severe mental illness such as psychosis may be unrecognized or unmet in postconflict settings, even though there is evidence that simple, low technology centers can be established to provide treatment.

VAN OMMEREN, M., SHARMA, B., SHARMA, G.K., KOMPROE, I.H., CARDEÑA, E., & DE JONG, J.T.V.M. (2002). **The relationship between somatic and PTSD symptoms among Bhutanese refugee torture survivors: Examination of comorbidity with anxiety and depression.** *Journal of Traumatic Stress*, 15, 415-421.

Examined the relationship between torture and somatic symptoms in 526 tortured and 526 nontortured Bhutanese refugees. In multivariate analyses that adjusted for anxiety and depression, number of PTSD symptoms was associated with somatic symptoms and number of involved organ systems.

VAN VELSEN, C., GORST-UNSWORTH, C., & TURNER, S.W. (1996). **Survivors of torture and organized violence: Demography and diagnosis.** *Journal of Traumatic Stress*, 9, 181-193.

Conducted structured diagnostic assessments with 60 treatment-seeking torture survivors. Most met criteria for PTSD (52%) or depression (35%). Beating was associated with more intrusion and sexual assault with more avoidance symptoms.

## PILOTS UPDATE

When we first offered online access to the PILOTS database, it was available only through a commercial database vendor, which charged several dollars for each search performed. Even when we were able to make searching free, there was still a major obstacle between users and the information they wanted. The database could identify publications on almost any aspect of traumatic stress studies, but the National Center was unable to supply copies. The best help we could offer was to direct searchers to the interlibrary loan department of their local library, or to a commercial document delivery service.

The growth of the World Wide Web has changed all that. In the past few years an increasing number of publishers have made current issues of their journals available online, and begun the process of digitizing back issues as well. The use of digital object identifiers (DOIs) ensures that online access to this material is not interrupted by reorganizations of publishers' websites. And cooperation among publishers, libraries, and abstracting and indexing services has facilitated the use of DOIs to link bibliographical citations and indexing records to the full text of the cited documents. The PILOTS Database was among the early affiliates of CrossRef, the nonprofit organization founded to promote this linking.

More than a quarter of the PILOTS Database records for journal articles now include links to full text. We expect this figure to increase. More publishers are making full text available, and several of the most important publishers are aggressively extending their retrospective full-text coverage. We regularly search CrossRef's extensive database to discover newly-available links to journal articles that we have indexed in the past, and add these to the existing records.

Publishers are beginning to assign DOIs and provide links to individual chapters of textbooks and reference works. This provides a new revenue stream for material that they have already paid for, giving them a strong incentive to expand this form of online publication. We understand that DOIs will also be assigned to doctoral

dissertations in the near future. If government agencies and nongovernmental organizations were to join this movement, it would greatly improve access to their often obscure publications.

We provide links from PILOTS Database records to full text only when we know those links to be reliable. It is no service to our users to offer links that do not work. Just because a DOI appears in the printed version of a journal article is no assurance that its content is actually available online. So we include DOI-based links only when we have tested them ourselves, or when we have obtained them from the CrossRef database. And we have been very sparing in our use of links that do not employ DOIs: most of those are to documents posted on the National Center's own website.

We intend to use our affiliation with CrossRef to expand our links to full text. We shall begin by retrieving DOIs that provide links to the full text of books and book chapters. We shall also establish links to theses and dissertations and to government documents and technical reports as these become available.

We are also examining the possibility of indexing selected Web resources — documents produced entirely for online consultation. Some of these are essentially books published online; others owe their form more to the particular capabilities of the World Wide Web than to the traditions of book and journal publishing. In considering which of these documents to index in the PILOTS Database, we shall be concerned with both the value of their content and the permanence of their existence. We do not wish to index publications that might not exist when database users attempt to read them. Unless its producers feel that a publication is valuable enough to form a part of the permanent archive, we cannot regard it as valuable enough to index.

Thus we shall proceed cautiously in choosing exemplars of this new form of publishing to include in the PILOTS Database. We welcome suggestions of those Web resources that would be most valuable to begin with.

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