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The Mechanisms of Psychosocial Injury Following Human Rights Violations, Mass Trauma, and Torture

Angela Nickerson and Richard A. Bryant, School of Psychology, University of New South Wales
Laina Rosebrock and Brett T. Litz, Massachusetts Veterans Epidemiological Research and Information Center

The pervasive negative impact of human rights violations (HRVs) on psychological functioning has been well documented. There is limited research, however, investigating the mechanisms that mediate the link between exposure to HRVs and various mental and behavioral health outcomes. We propose three theory- and evidence-based pathways by which HRVs may lead to psychosocial impairment, namely, disruptions in interpersonal processes, decreased perceptions of control, and the denigration of individual and group identity. We also underscore how the post-HRV environment moderates each of these pathways, and we describe the implications of the proposed model for clinical practice.

Key words: **complex trauma, depression, posttraumatic stress disorder, refugees, torture.** ***[Clin Psychol Sci Prac 21: 172–191, 2014]***

When human rights are systematically violated, the legacy can be enduringly toxic for individuals, cultures, and societies. In the context of political violence, events such as being threatened with death, witnessing the death of others, being tortured or raped, and witnessing atrocities are enacted with the purpose of instilling terror, exacting vengeance, or demonstrating the power of the perpetrating group (Basoglu, 2009; Goldhagen, 2009; Silove, 1999). For victims, these experiences are often also accompanied by forced disconnection from familial, social, cultural, and religious communities and resources. Not surprisingly, research has demonstrated that exposure to human rights violations (HRVs), coupled with enduring deprivation and adversity, affects mental health outcomes, most notably creating risk for psychological disorders such as posttraumatic stress disorder (PTSD) and depression (Fazel, Wheeler, & Danesh, 2005; Johnson & Thompson, 2008; Steel et al., 2009). There is a long-standing recognition, however, that these diagnostic categories may be inadequate to describe the effects of these events across multiple domains. Survivors of HRVs also often exhibit a range of other reactions, including profound and impairing changes to self-concept, self-efficacy, and core existential beliefs, as well as pervasive feelings of anger, humiliation, and betrayal (Barudy, 1989; Basoglu, Livanou, & Crnobaric, 2007; Gorst-Unsworth, Van Velsen, & Turner, 1993; Orgmann, Genefke, & Jakobsen, 1987; Silove, 1996, 1999; Silove, Tarn, Bowles, & Reid, 1991; Turner & Gorst-Unsworth, 1990).

Multiple frameworks have been developed that attempt to account for these disparate problems, with early proposed constructs derived from work with survivors of war and the Holocaust, including "concentration camp syndrome" (Bower, 1994; Chodoff, 1959), "KZ syndrome" (Krysinska, 2010; Niederland, 1968), and "survivor syndrome" (Niederland, 1968, 1981). Herman (1992) was the first to use the label "complex PTSD" in an attempt to capture the depth and chronicity of psychological disturbances following repeated interpersonal traumatization. This construct often refers to personality

Address correspondence to Angela Nickerson, PhD, School of Psychology, UNSW AUSTRALIA, Sydney NSW 2052, Australia. E-mail: anickerson@psy.unsw.edu.au.

changes involving deficits in emotion regulation, self-identity, and capacity to engage in adaptive relationships (Cloitre, Miranda, Stovall-McClough, & Han, 2005). Research investigating complex PTSD and related constructs such as enduring personality change after a catastrophic event (EPCACE; World Health Organization, 1992) and disorders of extreme stress not otherwise specified (DESNOS; Pelcovitz et al., 1997) has yielded mixed findings, with these disorders being criticized for inadequate coherence of criteria, lack of specificity, and poor stability across populations (Beltran & Silove, 1999; Bryant, 2012; de Jong, Komproe, Spinazzola, van der Kolk, & van Ommeren, 2005; Morina & Ford, 2008; Roth, Newman, Pelcovitz, van der Kolk, & Mandel, 1997; Weine et al., 1998). Consequently, to date, no universally accepted, comprehensive, and unified construct has been developed that adequately encapsulates the wide-ranging effects of exposure to HRVs.

Despite the documented impact of HRVs on core psychological functions, including identity, self-worth, and capacity to relate to others (Barudy, 1989; Basoglu et al., 2007; Gorst-Unsworth et al., 1993; Silove, 1996, 1999; Turner & Gorst-Unsworth, 1990), most research has focused on describing phenomenology and outcomes, rather than considering factors that cause psychopathology or promote adaptation and recovery. It is important to note that while rates of psychological disorders are high among survivors of HRVs, almost all studies have recorded a substantial group (often the majority) without significant formal mental disorders and functional impairment. Consequently, evaluation of the factors that differentiate those who recover and heal following HRVs from those who do not will significantly expand knowledge of the pathways from trauma to mental health outcomes and natural recovery. The elucidation of these underlying mechanisms would also directly contribute to the development of effective interventions to facilitate recovery following exposure to HRVs.

We draw on and integrate diverse lines of inquiry across multiple domains of human functioning (e.g., social, psychological, cultural) to propose three key pathways by which political violence, displacement, and refugee-related disruptions cause and maintain psychosocial injury, which we define as psychological distress and impairment in psychological and social functioning in survivors of HRVs. As presented in Figure 1, these pathways include (a) disturbances in interpersonal processes, (b) decreased perceptions of control, and (c) disruptions in individual and group identities. Deficits in these areas have been implicated in the development and maintenance of psychological disturbances, and each has been identified as a key factor associated with exposure to HRVs. To date, however, no research has examined the individual and combined associations between these factors and post-HRV mental health. Our proposed framework draws on and extends previous research and models of care

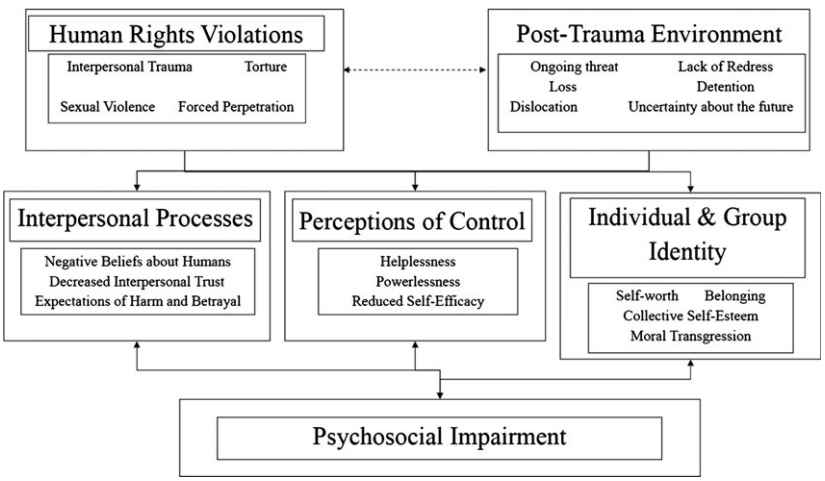

Figure 1. A Model of Mechanisms of Psychosocial Injury Following Human Rights Violations.

by integrating (a) established theoretical principles of the psychological effects of trauma, (b) empirical research evidence from clinical and social psychology, (c) clinical observations from work conducted with survivors of HRVs, and (d) key contextual factors related to HRVs. Our goal is to create a unified theoretical framework to guide the understanding of and research into mechanisms underlying the effects of HRVs. We first consider each of these mechanisms in the context of HRVs and then discuss the theoretical frameworks and empirical evidence surrounding each pathway. Finally, we propose a working causal model depicting the associations between HRVs, the proposed mechanisms, and psychosocial outcomes.

PROPOSED PATHWAYS FROM HRVS TO PSYCHOSOCIAL IMPAIRMENT

Disruptions in Interpersonal Processes

HRVs often occur in settings of mass violence or conflict and are characterized by interpersonal violence that is purposefully enacted to suppress dissent or denigrate a subgroup of the population. In such settings, it is common to be exposed to multiple instances and types of interpersonal trauma, such as being attacked or injured, witnessing the injury or death of loved ones or strangers, being sexually assaulted, or being tortured. Repeated exposure to interpersonal violations is often ongoing as a function of continued persecution and conflict. Even those who successfully flee are likely to experience further violence due to the frequent occurrence of interpersonal trauma in settings such as unstable neighboring countries, refugee camps, or immigration detention. Above and beyond the deleterious impact of these events on refugee mental health, researchers have noted that HRVs profoundly challenge conceptions of the benevolence of humankind and negatively affect interpersonal trust and functioning (e.g., Basoglu, 2009; Gorst-Unsworth et al., 1993). For example, a study conducted in the former Yugoslavia indicated that war survivors who had experienced traumatic events believed less in benevolence compared to control participants who had not been directly exposed to war (Basoglu et al., 2005). Torture provides an especially clear example of the destruction of assumptions about humankind. During torture, the relationship with the perpetrator, simultaneously characterized by dependence and extreme cruelty, is often used as a tool to cause psychological harm (Silove et al., 1991). A victim of torture at Auschwitz stated that "anyone who has been tortured remains tortured. Anyone who has suffered torture never again will be at ease in the world. Faith in humanity, already cracked by the first slap in the face, then demolished by torture, is never acquired again" (Amery, 1980, p. 3). As such, torture can be conceptualized as a strategic interpersonal violation.

A profound lack of trust in others is also a commonly observed consequence of HRVs (Beltran, Llewellyn, & Silove, 2008; Bychowski, 1968; Doerr-Zegers, Hartmann, Lira, & Weinstein, 1992; Gorst-Unsworth et al., 1993; Krysinska, 2010; Newman, Riggs, & Roth, 1997; Silove, 1996). In the context of collective violence, individuals are frequently placed in situations in which it is unclear who can be trusted and where misplaced trust may have catastrophic consequences. Family, former friends, and neighbors may act as informants or even perpetrators of violence; this betrayal is likely to challenge previous assumptions regarding the conduct of humankind in general. In such circumstances, negative expectations regarding the behavior of others may be adaptive, facilitating avoidance of potentially dangerous situations. Such expectations may linger even after relative safety has been achieved. Accordingly, it has been repeatedly noted that, even after reaching circumstances of safety (such as a country of asylum), mistrust is a common clinical characteristic in survivors of HRVs (Beltran et al., 2008; Bychowski, 1968; Doerr-Zegers et al., 1992; Gorst-Unsworth et al., 1993; Krysinska, 2010; Newman et al., 1997; Silove, 1996).

This is consistent with theories highlighting the pivotal role of core beliefs about the benevolence and trustworthiness of other people in the formation and maintenance of social relationships (e.g., Epstein, 2003; Janoff-Bulman, 1992). Janoff-Bulman (1992) proposed that interpersonal trauma challenges underlying assumptions about benevolence and meaning of the world. Charuvastra and Cloitre (2008) asserted that exposure to interpersonal trauma alters the perception that human behavior is guided by social rules. This process nullifies the sense of safety in social situations, compromising the capacity of the individual to form secure

attachment relationships, and diminishing expectations of support from others. Accordingly, the deleterious impact of childhood abuse (an interpersonal trauma occurring at a formative age) on attachment relationships and mental health has been well documented (Alexander et al., 1998; Cloitre, Stovall-McClough, Zorbas, & Charuvastra, 2008; Roche, Runtz, & Hunter, 1999; Van der Kolk, Perry, & Herman, 1991; Waldinger, Schulz, Barsky, & Ahern, 2006). Although it has not yet been systematically studied, it is reasonable to assume that severe, prolonged, interpersonal trauma in adulthood may also impact adult attachment and impair the individual's ability to make and sustain meaningful relationships. HRVs may thus be injurious by affecting core processes that facilitate the development and maintenance of healthy interpersonal relationships.

Empirical evidence for interpersonal violations as a pathway from HRVs to psychological distress can be drawn from two lines of research. The first, undertaken with trauma survivors, has documented the negative effects of prolonged, repeated, interpersonal trauma on survivors' capacity to relate to others. For example, a study conducted with women who had been abused as children found that poor expectations of interpersonal support and emotion dysregulation were key factors influencing the relationship between insecure attachment and psychological distress (Cloitre et al., 2008). Other studies have found that traumatic events characterized by betrayal are associated with higher levels of symptoms of borderline personality disorder (a disorder characterized by disturbed trust in others; Kaehler & Freyd, 2009) and that this relationship is partly mediated by health of community relationships (Belford, Kaehler, & Birrell, 2012). Further, betrayal beliefs following childhood sexual abuse are associated with greater interpersonal difficulties (Hazzard, 1993). Administering oxytocin, a neuropeptide known to enhance trust in healthy people, results in greater mistrust in people who have borderline personality disorder (Bartz et al., 2011); this suggests that the effects of complex traumatic experiences can alter fundamental biological responses that moderate interpersonal functioning.

The second sphere of research highlights the influence of generalized mistrust on psychological well-being. For example, extreme mistrust in other people has been related to interpersonal distress and negative affect (Gurtman, 1992), as well as insecure attachment (Mikulincer, 1998). In contrast, higher levels of trust have been related to more prosocial behavior (Cadenhead & Richamn, 1996), lower levels of psychological symptoms (Folkman, Lazarus, Gruen, & DeLongis, 1986), better physical health (mediated by anxiety and depression; Schneider, Konijn, Righetti, & Rusbult, 2011), and greater overall happiness (Tokuda, Fujii, & Inoguchi, 2010). Taken together, this research suggests that interpersonal trauma has a profound effect on trust and social functioning and is strongly related to negative mental health outcomes. Theoretical perspectives, empirical evidence, and clinical observations converge to highlight the important role of disruptions in interpersonal processes in the relationship between HRVs and a variety of psychosocial responses.

Decreased Perceptions of Control

HRVs, including witnessing the injury or death of a loved one, or being physically assaulted or tortured, place the individual in a state of helplessness. In settings where HRVs typically occur, the individual may be victim to countless unpredictable instances of persecution and violence; further, he or she may witness atrocities perpetrated against family, friends, or strangers while being powerless to intervene. This sense of helplessness may be compounded as the person is stripped of control of other areas of his or her life, for example, being forced to flee one's home, being unable to support one's family, or being unable to protect loved ones and possessions. Even in settings of relative safety, such as resettlement countries, survivors of HRVs may be subject to circumstances outside his or her control; this may include being placed in immigration detention or facing the prospect of being repatriated, compounding the associated sense of helplessness. This likely has significant implications for the individual's perception of his or her capacity to exert control on the world around him or her. Accordingly, research indicates that trauma-exposed survivors of the war in the former Yugoslavia reported a greater sense of loss of control (and associated poor adaptation) compared to individuals who had not been exposed to trauma (Basoglu et al., 2005).

Torture represents an extreme experience of uncontrollability. The individual is at the mercy of the torturer, who often uses techniques strategically designed to decimate perceptions of personal control, for example, by providing impossible choices such as threatening physical harm if the victim does not betray friends or comrades (Silove, 1996). Lack of control has been identified as an especially damaging aspect of torture (Silove et al., 1991). Accordingly, findings from studies conducted with torture survivors indicate that perceived uncontrollability of torture experiences is more strongly related to mental health outcomes, including PTSD and depression, than objective severity of physical torture (Basoglu, 2009; Başoğlu & Livanou, 2008).

Evidence for the salience of perceived control can be drawn from social learning theory (Bandura, 1977; Lefcourt, 1991), which highlights the importance of the individual's environmental context in the processes of learning and meaning making (Rotter, 1954). Rotter (1966) posited that internal locus of control results from the individual perceiving that environmental reinforcement is contingent on his or her actions, while external locus of control stems from beliefs that reinforcement occurs due to factors beyond the individual's control (e.g., luck or chance). Accordingly, external locus of control has been associated with depression and anxiety symptoms across cultural groups (Benassi, Sweeney, & Dufour, 1988; Cheng, Cheung, Choi, & Chan, 2013; Lu & Wu, 1998; Ormel & Schaufeli, 1991; Qin, Feng, Cao, & Yang, 2004).

Traumatic stress models have also highlighted the importance of perceptions of control during and after a traumatic event. Foa, Zinbarg, and Rothbaum (1992) used animal research to propose that the uncontrollability and unpredictability associated with traumatic events are a crucial component of the aversive influence of traumatic experiences on mental health. Ehlers and Clark (2000) also suggested that lack of control during trauma may be generalized to later perceptions of uncontrollability, if untreated. Frazier et al. (2011) asserted that perceptions of control over present and future stressors following exposure to trauma play a key role in well-being. Janoff-Bulman (1989) argued that perceived controllability of outcomes contributes to beliefs about meaningfulness of the world, an assumption that may be impacted by exposure to trauma.

Research findings regarding the relationship between perceived control over past traumatic events and subsequent well-being have been mixed. While some studies indicate that lack of perceived control at the time of the trauma is associated with worse psychological outcomes (e.g., Frazier, Steward, & Mortensen, 2004), others have found no relationship or that high levels of perceived control during a traumatic event are related to psychological distress, potentially due to self-blame (see Frazier, Bergman, & Steward, 2002). In contrast, findings regarding perceptions of control over one's current and future circumstances have consistently indicated that low perceived control is associated with poorer outcomes. For example, a study conducted with incest survivors found that mastery (defined as perceived ability to avoid abuse in the future and ability to handle situations in a way that achieves desired results) was significantly negatively related to depression and positively related to self-esteem and social functioning (Burke Draucker, 1989). Similarly, in a study with survivors of sexual abuse, Hazzard et al. (1993) found that powerlessness beliefs were related to lower self-esteem and greater depression symptoms. A study conducted with sexual assault survivors and bereaved individuals found that perceived control over posttrauma recovery was associated with lower distress (Frazier et al., 2004). Lower general beliefs about control also predicted greater psychological distress in survivors of a university shooting (Grills-Taquechel, Littleton, & Axsom, 2011).

Animal models have linked this sense of uncontrollability to "learned helplessness," originally observed in animals that, after learning that escape was not possible when subjected to a shock, reacted passively when later exposed to an escapable stressor (Overmier & Seligman, 1967; Seligman & Maier, 1967). Subsequent studies have found that animals administered escapable electric shocks are "immunized" against subsequent stressors relative to animals who are shocked that they cannot escape; this has been shown with a range of paradigms in which rats exposed to inescapable shock respond to subsequent stressors with increased fear conditioning, avoidance of a novel object, decreased social interactions, and increased social dominance (Christianson et al., 2008; Grahn, Watkins, & Maier, 2000; Maier & Watkins, 2005). The theory of learned helplessness was

later applied to humans (e.g., Abramson, Seligman, & Teasdale, 1978; Alloy, Peterson, Abramson, & Seligman, 1984) and used to conceptualize the etiology and maintenance of depression (Abramson et al., 1978; Seligman, Abramson, Semmel, & von Baeyer, 1979). When humans perceive that they have control over an aversive outcome (even if this perception is not realistic), they respond with lower physiological arousal (Geer, Davison, & Gatchel, 1970), fear and distress (Litt, Nye, & Shafer, 1993; Sanderson et al., 1989), and performance impairment (Glass et al., 1973) in relation to subsequent stressors.

By extension, these findings have substantial implications for survivors of HRVs, suggesting that beliefs about control may be strongly impacted by traumatic events, and are implicated in subsequent adaptation. Although many trauma survivors will experience a degree of perceived loss of control (Foa et al., 1992), it is likely that survivors of HRVs will experience this to a much greater extent because of their prolonged exposure to stressful events with unknown outcomes, such as torture, flight from persecution, and detention. Perceptions of control thus represent a potential pathway to psychological distress and well-being following exposure to HRVs.

Denigration of Individual and Group Identity

HRVs are often related to persecution on the basis of an aspect of ethnic, political, religious, cultural, or other identity. The denigration of an important component of identity via violence, devaluation, and dehumanization represents a key strategic goal of the enactment of HRVs. Accordingly, it has been noted that human rights violations pose profound challenges to preexisting conceptions of the individual's own self-worth and group identity (Barudy, 1989; Chodoff, 1959; Silove, 1999; Silove et al., 1991; Weine & Laub, 1995).

Denigration of Individual Identity. Violence, persecution, and the intentional infliction of trauma directly violate the status of the victim as a worthwhile human being, deserving of basic human rights. Being a victim of, witnessing, or being forced to perpetrate trauma represents fundamentally dehumanizing experiences that may profoundly alter the individual's conception of himself or herself as a worthy, moral, and acceptable person. Dehumanization, often a purposeful strategy in settings of collective violence, threatens the basic need to be validated as a human being by others (Barudy, 1989) and may have catastrophic effects on individual conceptions of self-worth. For example, during the Holocaust, Bychowski (1968) observed that

> [the Jewish] people has been treated not like human beings, but like vermin, fit only for extermination. Often women were asked to lie down in the mud so that SS men could walk over their bodies, living bodies, in order not to dirty their polished boots. These people were trampled upon literally, until their self-respect was destroyed. (p. 82)

Others have noted that, in such degrading contexts, individuals were no longer addressed by their names and were instead reduced to a number, effectively stripping them of individual identity and rendering them anonymous (Chodoff, 1959; Staub, 1999). Denied basic acknowledgment of their humanity, victims of HRVs evidenced changes in their perceptions of their own status and value as human beings.

Being forced to perpetrate HRVs may represent the ultimate insult to individual identity. A salient example is child soldiers who may be forced to harm or kill others, including family members and/or friends, to destroy ties with their home communities (Betancourt et al., 2010). Individuals who are tortured are also often forced to transgress their own moral codes by engaging in acts of a violent, sacrilegious, humiliating, or sexual nature. This is done to ensure that the individual is returned to the community with maximum psychological damage, thereby conveying to others the consequences of resistance or insurgency (Silove, 1996). Weine and colleagues (1995) asserted that "being subject to, witnessing, or being forced to perpetrate atrocities against another leaves the survivor feeling humiliated, helpless, no longer human, even a true beast oneself" (p. 540). Such acts have substantial consequences for the individual's identity and perception of his or her own worth as a human being. It is important to note that, in the case of perpetration (forced or otherwise), the individual's response will be idiosyncratic and is likely to be influenced by his or her perception of consistency between the acts and

held values. It is proposed that greater psychological damage may occur when the perpetrated acts are ego-dystonic, for example, in the case of forced perpetration.

Conceptions of self-worth are recognized as necessary ingredients of human well-being. Janoff-Bulman (1992) described self-worth as the extent to which one perceives himself or herself as being a "good, capable, and moral" individual (p. 11). Epstein (1973, 1991) argued that the view of the self as worthy represents a basic need of humankind. Accordingly, theorists have highlighted the potential deleterious impact of traumatic events on the individual's beliefs about himself or herself. Ehlers and Clark (2000) asserted that disturbances in self-beliefs are common consequences of exposure to traumatic events and are associated with subsequent psychopathology. Janoff-Bulman (1992) argued that traumatic experiences, particularly human-perpetrated events, may negatively affect the victim's view of his or her own value, for example, by challenging conceptions of autonomy, strength of will, and capability. How one views oneself also plays an important role in guiding human understanding of, and interactions with, the external world. For example, Janoff-Bulman (1992) argued that beliefs about self-worth have a strong impact on the individual's self-perceived capacity to manage situations and control outcomes.

Research has documented the link between self-worth and related constructs, and psychosocial outcomes. For example, research suggests that low self-esteem mediates the relationship between adult attachment and depression (Roberts & Bengston, 1996). A study conducted with Vietnamese migrants found that negative self-esteem (also impacted upon by ethnic identity) was related to greater psychological distress (Nesdale, Rooney, & Smith, 1997). Research with Hispanic college students indicated that self-efficacy moderated the relationship between stress, and physical and psychological distress (Solberg & Viliarreal, 1997). Results from a meta-analysis indicate that appraisals regarding self-efficacy are strongly associated with health-related outcomes (Holden, 1991). Self-worth can also impact on social behaviors; for example, Park and Maner (2009) found that when individuals with low self-esteem experienced self-threat, they were more avoidant of social contact.

Beliefs about the self also substantially contribute to psychological outcomes following exposure to traumatic events. Ali, Dunmore, Clark, and Ehlers (2002) found that individuals who had experienced an interpersonal assault and had PTSD reported more negative beliefs related to self-worth following the assault than those who had not experienced an assault and those who had experienced an assault but did not have PTSD. In a study of assault victims, Dunmore, Clark, and Ehlers (1999) found that "permanent change," referring to the extent to which the individual felt he or she had been irreversibly damaged or changed as a person by the assault, was significantly related to the onset and maintenance of PTSD symptoms. In a longitudinal investigation of the relationship between post-trauma appraisals and PTSD symptoms, negative beliefs about the self were the strongest predictors of psychological distress 12 months following a trauma (O'Donnell, Elliott, Wolfgang, & Creamer, 2007). Negative self-beliefs (influenced by depression) also mediated the association between past trauma exposure and acute symptoms of traumatic stress following the 9/11 terrorist attacks (Nixon & Nishith, 2005). Benight and Harper (2002) found that coping self-efficacy, a related construct, mediated the relationship between acute stress reactions and PTSD symptoms in a study of survivors of natural disasters. Low self-worth also predicted psychological distress in survivors of a university shooting (Grills-Taquechel et al., 2011). Overall, this evidence suggests that self-worth and individual identity play a key role in the development and maintenance of posttraumatic psychological distress.

Denigration of Group Identity. In the context of HRVs, persecution is often enacted on the basis of actual or perceived membership of a national, ethnic, political, or other group (Moshman, 2007; Turner & Gorst-Unsworth, 1990). Group identity, previously a source of pride and identification, may instead become a locus of persecution and suffering. The victim ceases to be considered an individual, instead being viewed as representative of the group, which is devalued and denigrated. HRVs are thus enacted, not only to eliminate dissent and prevent subversion, but also with the purpose of damaging the identity of the targeted group. This can represent a key strategy in settings of violence.

For example, rape camps were established in the former Yugoslavia with the purpose of impregnating women to achieve cultural dilution, thus contributing to the state-sanctioned policy of ethnic cleansing (Salzman, 1998). Further, evidence of the strategic destruction of group identity can be seen in the actions of colonizing governments that implemented genocidal policies with the goal of annihilating local cultures and communities to obtain power and resources (Madley, 2004; Moses, 2002; Palmer, 2000). Important aspects of religious and cultural identity may also be attacked, as evidenced by the persecution of Buddhist monks in Tibet, the forced conversion of non-Muslims in Iraq, and the destruction of religious symbols in Gujarat, India (Petit, Ford, & Jain, 2007). The recruitment of members of the persecuted group to act as informants and perpetrators, common in these settings, further damages the integrity of the group and decreases the sense of belonging and community. In addition to affecting group identity, these processes are likely to have significant implications for the individual's concept of himself or herself, as a valued aspect of his or her identity is attacked. As Krystal and Niederland (1968) stated, "when an entire population is reduced to an inferior status ... the individual's self-respect is damaged in ways not repairable by himself" (p. 5).

Group identity is also pivotal to individual well-being (Lewin, 1948). Social identity theory posits that individuals are driven to maintain a positive group identity, which provides the person with a sense of meaning and belonging (Tajfel, 1981; Tajfel & Turner, 1979). Group identity plays a key role in self-concept (Tajfel & Turner, 1979; Taylor & Usborne, 2010), with personal identity being shaped through interactions between the individual, the larger group, and social systems (Barudy, 1989). Collective identity also provides a template against which the individual can evaluate the self, thus directly contributing to individual identity (Brewer & Gardner, 1996; Taylor & Usborne, 2010).

The construct of collective self-esteem was developed to index "the extent to which individuals generally evaluate their social group positively" (Crocker & Luhtanen, 1990, pp. 60–61). Convergent research suggests that the manner in which the group is treated can have direct effects on collective self-esteem and other individual-level outcomes. For example, perceived social status has been found to be positively related to collective self-esteem (Verkuyten & Lay, 1998). Being part of a devalued social group is also associated with a range of negative emotional and social outcomes (Crocker & Major, 1989), including denigrated collective self-esteem, which, in turn, is linked to negative psychological outcomes (Katz, Joiner, & Kwon, 2002). Collective self-esteem has been associated with numerous positive outcomes, including life satisfaction, psychological health, and subjective well-being (Bettencourt & Dorr, 1997; Crocker, Luhtanen, Blaine, & Broadnax, 1994; Lam, 2007). Low collective self-esteem has been linked with greater perceptions of racism (Rahimi & Fisher, 2002) and psychological maladjustment (Yoon, 2001). A decreased sense of belonging has also been associated with a range of physical and psychological problems (Baumeister & Leary, 1995), including symptoms of depression, suicidality, and lower self-efficacy (Kia-Keating & Ellis, 2007; McCallum & McLaren, 2011; McLaren, 2009; McLaren & Challis, 2009). Changes in individual and group identity following HRVs represent important pathways to posttraumatic psychopathology and functional impairment.

MECHANISMS UNDERLYING PSYCHOSOCIAL INJURY FOLLOWING HRVS: AN INTEGRATED MODEL

We draw on theoretical frameworks, empirical findings, and clinical observations presented thus far to propose an integrated model of the mechanisms underlying psychological distress and functional impairment following exposure to HRVs. This model, presented in Figure 1, proposes that exposure to HRVs directly leads to disruptions in interpersonal processes, decreased perceptions of control, and denigrations in individual and group identity. These mechanisms are also impacted on by, and contribute to, the posttrauma environment and mediate the association between these experiences and psychosocial impairment. We discuss each proposed mechanism separately below.

Interpersonal Processes

As noted above, HRVs are frequently interpersonal in nature; unlike accidental trauma and natural disasters, these events are enacted on humans by other humans,

with key examples encompassing torture, sexual violence, and forced perpetration. We propose that disrupted interpersonal processes following HRVs lead to negative psychosocial outcomes by challenging fundamental beliefs about the moral nature of human beings. The denigration of these beliefs likely impacts on a variety of processes, including attentional focus toward negative interpersonal behavior, perceptions of impaired safety, and disrupted attachments. For example, repeated exposure to interpersonal trauma may facilitate attentional biases to evidence of interpersonal violations and expectations of harm and betrayal, leading individuals to negatively interpret the actions of others when in ambiguous social situations. Vigilant self-protection against negative interpersonal outcomes, while adaptive in a setting characterized by violence, may have deleterious psychological consequences in safe contexts by interfering with the individual's capacity to benefit from countervailing relational experiences and maintaining suspicion, threat, and isolation. Consequently, mistrust feeds on itself and reinforces global negative expectations regarding the behaviors of others, providing increasingly greater evidence to support negative interpersonal beliefs and expectations.

The association between HRVs and disturbed interpersonal processes may directly impact on psychological outcomes via a number of conduits. For example, if humans are seen as potentially threatening, the individual may avoid them or take defensive action to prevent harm or betrayal. Beliefs and behaviors regarding the danger of engaging with other people may contribute to psychological symptoms such as avoidance in PTSD, anxiety reactions, and social withdrawal in depression or manifest in anger reactions that are triggered by innocuous situations that are incorrectly perceived as threatening. In addition to creating barriers to obtaining corrective information regarding global negative beliefs about others, this may decrease the capacity of the individual to form and maintain meaningful relationships, reducing expectations of support and contributing to outcomes such as interpersonal dysfunction, attachment disturbance, antisocial behavior, and social isolation. These consequences directly interfere with the formation of social networks that are important for posttrauma recovery, further compounding psychological symptoms and eliciting impairment in important areas of functioning, such as social, familial, educational, and occupational domains.

The effect of interpersonal violations on survivors of HRVs may be especially pernicious at early developmental stages. Research has suggested that prolonged interpersonal trauma that occurs in childhood may have long-lasting effects on the capacity of individuals to form and maintain healthy and supportive interpersonal relationships (Alexander et al., 1998; Cloitre et al., 2008; Roche et al., 1999; Van der Kolk et al., 1991; Waldinger et al., 2006). Repeated exposure to evidence of human malevolence at a young age may thus contribute to disruptions in social development, potentially precipitating a spiral of ongoing psychosocial injury that may stretch into adulthood.

Perceptions of Control

Exposure to multiple situations in which one has little or no control or in which control is purposefully withheld, such as in HRVs and conflict-related settings, is likely to have a pervasive effect on the way the individual interacts with the world and on psychological well-being. Repeatedly being placed in a position of helplessness may alter the individual's belief that he or she is able to exert control over the external world, potentially leading to reduced conceptions of self-efficacy and personal competence. As noted, this can lead to a range of psychological problems via biological and cognitive pathways. In addition to altering self-concept (as discussed further below) and contributing to feelings of powerlessness, a reduced sense of control may impact on the way in which the individual views situations in which controllability is unclear. For example, it is possible that individuals who have repeatedly been denied control then tend to underestimate the potential controllability of an ambiguous situation. Further, their conception of their personal capacity to engage in effective action may be greatly reduced.

The belief that one has a limited capacity to control external events, and the interpretation of ambiguous situations as being uncontrollable, may then directly impact on the individual's behavior. For example, a sense of powerlessness or helplessness may manifest in reduced attempts to engage with the environment or solve problems as they arise. As outlined previously, research suggests that perceptions of uncontrollability

reduce one's capacity to manage subsequent stressors effectively, as well as worsening associated distress. This may contribute to psychological difficulties by promoting withdrawal and avoidance of difficult situations and feared stimuli, thus maintaining and exacerbating depression and anxiety reactions. Decreased perceptions of control may also interact with disturbed interpersonal processes to highlight the uncontrollability and threat associated with social situations, compounding the effects of social withdrawal and isolation. Alternatively, a sense of global lack of control may manifest in frustration and anger; accordingly, anger reactions are well documented in survivors of HRVs who have been repeatedly exposed to unjust and uncontrollable events (Brooks, Silove, Steel, Bateman-Steel, & Rees, 2011; Hinton, Rasmussen, Nou, Pollack, & Good, 2009; Nickerson & Hinton, 2011; Silove et al., 2009). Behavioral reactions including withdrawal, avoidance, and the expression of anger will increase the likelihood of negative outcomes, potentially also augmenting the sense of uncontrollability and providing further evidence supporting global beliefs about control and efficacy.

Individual and Group Identity

Victims of HRVs are treated as worthless and deprived of basic levels of respect, as a function of being subject to or witnessing events such as injury, torture, rape, and/or murder. Repeated devaluation and dehumanization is likely to have a profound impact on the self-concept of the individual and the extent to which he or she considers himself or herself a worthwhile person. In some cases, individuals may even be forced to perpetrate HRVs, directly transgressing their own moral standards and challenging their perception of themselves as moral beings. The effect of these events on identity endures long after the trauma itself, as described by the construct "permanent change," which was developed to describe the feeling of being irreversibly altered following exposure to a trauma (Dunmore et al., 1999).

The denigration of group identity is also often a systematic strategy in settings of collective violence, designed to irrevocably alter internal and external conceptions of important groups (Taylor & Usborne, 2010). This is likely to impact on the status of the group in society overall, the collective self-esteem and sense of belonging that the individual derives from group membership, and the individual's own sense of self. As outlined previously, empirical research indicates that decreased self-esteem and belonging will afford a multitude of negative consequences, spanning psychological, social, emotional, perceptual, and functional domains. Further, the potentially positive aspects of group membership, including a sense of belonging and shared experience, may be negated by the deliberate infusion of mistrust, which represents an especially destructive strategy aimed at eroding collective identity. Betrayal and perpetration by in-group members divide previously cohesive communities along invisible lines. Basic bonds and attachments to family, friends, and other community members may be broken, and the role of society as an overall organizing context providing support and a sense of community identity may be destroyed.

The dual assault on individual and group identity in the context of HRVs is likely to be especially damaging and may contribute substantially to negative psychological, behavioral, and functional outcomes. For example, failure to see oneself as a worthwhile person combined with a disrupted sense of belonging as a function of exposure to HRVs may lead an individual to withdraw socially, resulting in depressed mood and limited opportunities to challenge negative beliefs about the self. Low self-worth, combined with negative expectations of others as a function of disturbed interpersonal processes, may perpetuate cycles of retraumatization and revictimization. Further, low self-esteem, as a result of dehumanization and devaluation, may also reinforce low self-efficacy due to decreased perceptions of control. Further, low levels of self-worth may be associated with risky behavior, such as the abuse of alcohol or drugs or self-harm, further contributing to mental health difficulties and functional impairment.

Posttrauma Environment

Much research has attested to the pivotal importance of the posttrauma environment in promoting psychological recovery following exposure to a traumatic event (Johnson & Thompson, 2008; King, King, Fairbank, Keane, & Adams, 1998; Simon, 1999). The capacity of the post-HRV environment to negatively or positively

impact on posttrauma adjustment and well-being has also been demonstrated by numerous studies. For example, research has consistently indicated that, for refugees, the postmigration environment strongly contributes to postresettlement mental health, even after controlling for the effects of trauma exposure (e.g., Gorst-Unsworth & Goldenberg, 1998; Laban, Gernaat, Komproe, van der Tweel, & De Jong, 2005; Nickerson, Bryant, Steel, Silove, & Brooks, 2010; Porter & Haslam, 2005; Steel, Silove, Bird, McGorry, & Mohan, 1999). Evidence-based models for the treatment for PTSD developed in Western settings focus on assisting the survivor to process the traumatic experience in the context of safety and to correct maladaptive and unrealistic appraisals of the trauma, the self, and the world (Ehlers & Clark, 2000; Foa & Rothbaum, 1998; Resick & Schnicke, 1992). These models implicitly assume an objective level of safety in the survivor's environment, and the availability of disconfirming information and healing social experiences (Marshall et al., 2007). However, aspects of the posttraumatic or peritraumatic environment following HRVs may present formidable challenges to repairing beliefs, rebuilding identities, and promoting well-being. In general, continuing conflict or displacement to dangerous settings such as unstable neighboring countries, refugee camps, or immigration detention centers may preclude the objective safety required to recover from the effects of trauma. In settings of collective violence, the capacity of institutions to facilitate posttrauma recovery (e.g., by providing health care, mental health services, and social welfare) is likely to be compromised. Alternatively, these institutions may play a role in the perpetration of violence; for example, medical and mental health professionals may be enlisted to oversee or perpetrate torture practices (Sudfeld, 1990), and previously safe service settings may be transformed into contexts of oppression (e.g., Saddam Hussein's torture centers in Iraqi police stations [Stover, 1992], the school that became the Tuol Sleng torture center in Cambodia [Chandler, 2000], detention of political dissidents in psychiatric institutions [Amon, 2010]). Even after the violence has ceased, it is common for perpetrators to live side-by-side with their victims, particularly if the governing regime is still in power. This can create circumstances of impunity in which victims have no course of redress for acts that have been perpetrated against them (Basoglu et al., 2005; Fisher, 1999; "Rwanda: Living Side by Side," 2008).

Each of the three pathways outlined here may be impacted on by (and also influence) circumstances in the posttrauma environment. In the case of interpersonal violations, the facilitation of trust in others may be difficult or dangerous in the context of the continued suspension of social norms that generally dictate human behavior in conflict and postconflict environments. For example, if violence, persecution, and associated interpersonal trauma are ongoing, there will be mounting evidence of the malevolence of humankind and trust in others may be ill advised. Individuals may also be separated from important sources of support via death, imprisonment, or displacement. This impoverishment of social support may interact with general mistrust and maladaptive attachment to impede access to previous sources of support or the formation of new support networks. Perceptions of lack of control may be underscored by scarce resources, protracted asylum claims, immigration or political detention, or fear of being returned to one's homeland. Dehumanization in settings such as refugee camps and immigration detention centers, and significant status changes in new settings where previous qualifications and roles may not be recognized are likely to contribute to decreased self-worth. Group identity may also be further damaged by displacement from one's community and impediments to the performance of rituals and processes important to the maintenance of group identity because of cultural destruction, institutionalized policies, and/or logistic challenges. In summary, the posttrauma environment may have a substantially injurious effect on individual well-being by providing a hostile setting for recovery.

Conversely, the posttrauma environment provides an important context for encouraging recovery from the effects of exposure to HRVs. Although such settings may cement altered processes, beliefs, and perceptions, they can also facilitate healing and adaptation. A context that provides a safe, secure, and warm environment following HRVs may provide alternative evidence for negative beliefs about the self, other humans, and the world in general. For example, if the individual is reunited with family members or provided

with some form of social support following exposure to HRVs, he or she may have the opportunity to observe positive and prosocial human behavior and hence be able to foster meaningful relationships with others. The provision of some control over one's environment, for example, deciding where to resettle if displaced, having the freedom to restart one's life, and being able to take care of one's family, may combat perceptions of helplessness and assist with restoring beliefs about general controllability of the world. Being able to engage in meaningful activities, such as work or education, may furnish the individual with a valuable opportunity to repair conceptions of his or her own self-worth. Taking part in important cultural and/or religious rituals and connecting with others in one's community may also contribute to restoring a sense of group identity, belonging, and connectedness. Each of these processes potentially has important positive implications for psychosocial functioning. Overall, the posttrauma environment plays a key role in alleviating or compounding the effects of HRVs on subsequent psychological well-being.

Prevention and Treatment Implications

The model we propose holds promise for future directions in preventing and treating mental health disorders and improving psychosocial functioning in survivors of HRVs. The consensus evidence-based early intervention and treatment recommendations for posttrauma responses promote trauma-focused interventions that target acquired conditioned fear based primarily on life-threat trauma. This is consistent with current conceptualizations of posttraumatic stress responses that are based on fear conditioning models (e.g., Davis, Myers, Chhatwal, & Ressler, 2006; Foa, Steketee, & Rothbaum, 1989; Keane, Zimmerling, & Caddell, 1985; Litz & Bryant, 2009). These interventions traditionally focus on the therapeutic reliving of a traumatic memory and correcting maladaptive appraisals of the trauma, which serve to reduce anxiety and decrease intrusive memories and associated recovery-thwarting avoidance. As we have described, the injurious effects of HRVs occur through multiple pathways that extend beyond fear responses, and the outcomes associated with these experiences may not be sufficiently predicted or described by a conditioning framework.

One critical question is whether it is necessary to develop models of prevention and treatment that specifically target factors that cause posttraumatic symptoms and functional impairment after exposure to HRVs. One of the most strongly validated treatments for PTSD is prolonged exposure therapy, which requires repeated imaginal reliving of the trauma memory (Foa & Rothbaum, 1998). Although often conceptualized as an intervention that promotes habituation to the feared stimuli, exposure therapy also facilitates the integration of corrective information, as well as promoting a sense of self-mastery as the individual learns to manage his or her traumatic memories (Jaycox & Foa, 1996; Rothbaum & Mellman, 2001; Rothbaum & Schwartz, 2002). These mechanisms may impact on the processes proposed in this model, for example, by enhancing perceptions of control, and assist the HRV survivor to access information that counters negative beliefs about the self and the world. Further, since the introduction of prolonged exposure, there have been numerous innovations in contemporary intervention frameworks to address themes such as those outlined in this model. For example, cognitive processing therapy (Resick, Monson, & Chard, 2008; Resick & Schnicke, 1992) directly targets themes such as shame and guilt, which may be key sequelae impacting on individual and group identity following persecution or torture. This intervention has demonstrated efficacy in reducing PTSD symptoms in Western groups (e.g., Chard, 2005; Monson et al., 2006; Resick, Nishith, Weaver, Astin, & Feuer, 2002) and, more recently, has been adapted for refugees and torture survivors (Kaysen et al., 2013; Schulz, Resick, Huber, & Griffin, 2006). Similarly, a cognitive model of PTSD posited by Ehlers and Clark (2000), and the associated intervention (which has been supported by substantial research evidence; Duffy, Gillespie, & Clark, 2007; Ehlers et al., 2005, 2003), highlights the primacy of trauma appraisals relating to the self and the external world, which may relate to interpersonal violations, perceptions of control, and individual and group identity. Further, recent research has attested to the efficacy of narrative exposure therapy (Schauer, Neuner, & Elbert, 2005) in reducing symptoms of PTSD and improving functioning in a variety of groups exposed to war and/or torture (see Robjant & Fazel, 2010, for a review). This intervention incorporates a testimonial component

in which patients have the opportunity to send their autobiographical story to human rights agencies or other organizations; this may restore some sense of control in survivors of HRVs.

However, while themes relating to shame, guilt, and redress have been considered in psychological interventions, disruptions in interpersonal processes, control, or identity are not the primary focus of best-practice interventions that center on memory integration, elaboration, or processing. The challenges in effectively treating individuals exposed to human rights violations are well known (see Nickerson, Bryant, Silove, & Steel, 2011). There is a need to evaluate the effectiveness of current intervention approaches in addressing these maintaining factors; this may require new ways of conceptualizing targets of change in addition to examining the capacity of these treatments to reduce symptoms and improve functioning in the context of HRVs.

The proposed model offers testable means to augment treatment outcomes in victims of HRVs by directly focusing on interpersonal processes, enhancing control, addressing anticipatory anxiety about future dislocation or threat, meeting immediate needs, focusing on themes of betrayal and shame, and integrating concepts of individual and social identity into treatment. These elements are posited to promote recovery and adaptation after HRVs, and we hypothesize that the direct targeting of these factors will enhance psychosocial outcomes when paired with current evidence-based approaches such as cognitive behavioral therapies. As noted, the empirical basis for generating interventions uniquely suitable for survivors of HRVs and refugees is scarce (Nickerson et al., 2011), and so controlled evaluation of programs that integrate various factors of this model may extend the knowledge base and shape more tailored interventions for survivors of HRVs.

CONCLUSIONS AND FUTURE RESEARCH

In this article, we integrated existing lines of theoretical and research inquiry to propose a comprehensive model of the mechanisms underlying the relationship between exposure to HRVs and psychological suffering and functional impairment. These pathways, proposed to contribute to the onset and maintenance of negative mental health outcomes, encompass disturbances in interpersonal processes, decreases in perceptions of control, and disruption of individual and group identities. Each pathway was derived from theoretical models, clinical observations, and empirical research, but none has yet been systematically empirically investigated in the context of HRVs. Rigorous empirical research needs to be conducted to elucidate the role of each of these processes in posttrauma outcomes across adult and child populations exposed to HRVs. Further, such research should take into account the potentially compounding or healing impact of the posttrauma environment that commonly surrounds HRVs. Clear evidence regarding key factors underlying psychological distress following exposure to HRVs would have significant implications for the development of treatment interventions that directly target maintaining factors to reduce distress and functional impairment in individuals exposed to HRVs.

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