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'Means of Survival' as Moderator of the Relationship between Cumulative Torture Experiences and Posttraumatic Stress Disorder among Refugees

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ACCEPTANCE

This dissertation, 'MEANS OF SURVIVAL' AS MODERATOR OF THE RELATIONSHIP BETWEEN CUMULATIVE TORTURE EXPERIENCES AND POSTTRAUMATIC STRESS DISORDER AMONG REFUGEES, by LYDIA ODENAT, was prepared under the direction of the candidate's Dissertation Advisory Committee. It is accepted by the committee members in partial fulfillment of the requirements for the degree Doctor of Philosophy in the College of Education, Georgia State University.

The Dissertation Advisory Committee and the student's Department Chair, as representatives of the faculty, certify that this dissertation has met all standards of excellence and scholarship as determined by the faculty. The Dean of the College of Education concurs.

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ABSTRACT

'MEANS OF SURVIVAL' AS MODERATOR OF THE RELATIONSHIP BETWEEN CUMULATIVE TORTURE EXPERIENCES AND POSTTRAUMATIC STRESS DISORDER AMONG REFUGEES

by

Lydia Odenat

Refugee torture survivors often present with a myriad of psychological challenges, such as posttraumatic stress and depression, stemming from their exposure to torture and other pre- and post-settlement experiences (Gong-Guy and colleagues, 1991). The present study examined the moderating effect of four coping processes (i.e., family support, religious beliefs, political beliefs, and will to survive) on the relationship between cumulative torture and posttraumatic stress disorder (PTSD) among a sample of 204 (N=204) adult refugee torture survivors. Subjects completed a demographic questionnaire, the Torture Severity Scale (TSS; Kira, Lewandowski, Templin, Ramaswamy, Ozkan, Hammad, & Mohanesh, 2006), the Clinician Administered PTSD Scale (CAPS-2; Weathers, Keane, & Davidson, 2001), and the Means of Survival Scale (MOS; Kira, 2012). Twenty-three percent (N = 74) of the sample endorsed clinically significant levels of PTSD. Torture and PTSD were positively associated, indicating that greater exposure to cumulative torture is associated with greater trauma symptoms (r[2] = .18, $p<.01$). Significant positive correlations were found between will to survive and cumulative torture (r[2] = .31, $p<.01$), PTSD and political beliefs (r[2] = .13, $p<.05$), PTSD and will to survive (r[2] = .141, $p<.05$), religious beliefs and will to survive (r[2] = .15, $p<.01$), and family support and will to survive (r[2] = .130, $p<.05$). Results of the regression analyses demonstrated that CTE (b=.12, p=.035) and political beliefs (b=.17, p=.002) were significant predictors of PTSD symptoms in this sample, $R^2 = .039$; F

(2,323) = 7.55, p=.001. None of the interaction terms examined accounted for significant variation in PTSD symptoms. Study findings will help counseling psychologists devise the most appropriate treatment plans and strategies to treat posttraumatic stress reactions among refugee torture survivors, as well as inform future interventions developed for this vulnerable population.

‘MEANS OF SURVIVAL’ AS MODERATOR OF THE RELATIONSHIP BETWEEN CUMULATIVE TORTURE EXPERIENCES AND POSTTRAUMATIC STRESS DISORDER AMONG REFUGEES

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ABBREVIATIONS

CTE	Cumulative Torture Exposure
DESNOS	Disorders of Extreme Stress Not Otherwise Specified
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders – 4th edition
MOS	Means of Support
PTSD	Posttraumatic Stress Disorder

CHAPTER 1

BEYOND PTSD: APPLYING DESNOS TO THE EXPERIENCES OF REFUGEE SURVIVORS OF TORTURE

The use of torture remains a global public health problem among refugees and has been shown to have long-standing impact on individuals, their families, and communities (Grodin et al., 2008). Evidence suggests that between 5% and 35% of refugees who present in camps and treatment centers around the world are reportedly victims of torture (Jaranson, Butcher, Halcon, Johnson, Robinson, Savik, Spring, & Westermeyer, 2004), with even higher estimates up to 50% among certain ethnic groups (Grodin, Piwowarczyk, Fulker, Bazazi, & Saper, 2008; Jaranson et al., 2004). With roughly 400,000 to 500,000 refugee survivors of torture residing in the United States alone (Gorman, 2001; Newall, 2007), counselors are increasingly likely to encounter this vulnerable population in a variety of treatment settings, ranging from schools to government agencies (Marotta, 2003). Despite these harrowing numbers, mental health and other care providers continue to be inadequately trained to meet the medical and mental health needs of this population (Lears & Abbott, 2005)

Refugee torture survivors often present with a myriad of psychological and physical consequences of torture, displacement, indiscriminate violence, and deprivation (Gong-Guy, Cravens, & Patterson, 1991; Lears & Abbott, 2005; Tamblyn, 2011). Studies have shown high rates of psychoses (Kroll, Yusuf, & Fujiwara, 2011), somatic complaints and chronic pain (Goldfeld et al., 1988; Punamaki, Qouta, & El Sarraj, 2010), substance abuse (Holmqvist, Anderson, Anjum & Alinder, 2006), depression (Ellis, MacDonald, Lincoln, & Cabral, 2008), anxiety symptoms (Sachs, Rosenfeld, Llewa,

Rasmussen, & Keller, 2008), dissociative disorders (Thapa, Ommeren, Sharma, de Jong, Hauff, 2003), and impaired memory (Gorman, 2001) in this population. A significant number of refugees continue to develop symptoms of posttraumatic stress, depression, anxiety, sleep disturbance, and somatic complaints even years after exposure to torture (Grodin, et al., 2008; Hargreaves, 2002; Holmqvist et al., 2006; Jaranson et al., 2004; Lindencrona, Ekblad, & Hauff, 2008; Olsen, Montgomery, Bojholm, & Foldspang, 2007). It is well documented in the research literature that torture exposure not only has significant impact on a refugees' psychosocial functioning, but has deleterious effects on their capacity to resettle and integrate into a new society (Grodin et al., 2008). These traumatic experiences bear a major burden on the lives of refugees and carry an enormous cost to society when left unaddressed.

Posttraumatic stress disorder (PTSD) is a chronic condition that involves the re-experiencing of traumatic events, heightened arousal, avoidant behaviors and emotional numbing that inhibit normal functioning (Jaranson et al., 2004; Ford, Stockton, Kaltman, & Green, 2006). Among refugee torture survivors, it is estimated that roughly 16-37% develop a lifetime diagnosis of PTSD (de Jong, Komproe, & Ommeren, 2001). Other researchers have found prevalence rates as low as 4% to as high as 86% in other samples (Jaranson et al., 2004; Lueger-Schuster, 2010). Clinical reports of sufferers have shown that they present with a wide range of traumatic stress reactions, including impairments in self-regulation, chronic depression, anxiety, somatic complaints, feelings of fear, demoralization, rage, and loss of control (Basoglu, 2006). Common clinical presentations include poor coping strategies, impaired self-perception, survivor's guilt, shame, distrust of others, and loss of hope (Chung, 2001, Gorman, 2001; Regel & Berliner, 2007).

Substance abuse, self-injury, fugue, ego fragmentation, re-victimization, impairments in identity and personality, and impulsivity are also frequently observed among chronically traumatized refugees (Berliner et al., 2004; Cook, Blaustein, Spinnazola, & van der Kolk, 2003). These symptoms typically interfere with their day-to-day functioning and when left untreated, often persist throughout their lifetime (Lears & Abbott, 2005).

The aim of the present article is to illustrate that PTSD, as a culture-bound diagnostic model, does not fully address the unique trauma responses of refugee torture survivors. The broad variability in the PTSD rates among this population is indicative of the difficulties involved in framing their distress symptoms within the context of PTSD. The authors offer up Disorders of Extreme Stress Not Otherwise Specified (DESNOS) (Herman, 1996) as a viable framework to conceptualize the experiences of refugees following exposure to torture. DESNOS is an alternative model that addresses the pervasive disturbances in perception, affect regulation, personality development, and impulse control that often occur in response to severe and prolonged traumatization among survivors of torture (Liebenberg & Papaikonomou, 2010; Luxenberg, Spinazzola, & van der Kolk, 2001).

Clinicians working with refugee victims of torture have found that the PTSD diagnosis, as it currently stands, does not adequately account for the diversity of symptoms experienced by traumatized refugee torture survivors (Berliner, Mikkelsen, Bovbjerg, & Wiking, 2004). Above and beyond symptoms of re-experiencing, avoidance, and hyperarousal, researchers in one study found significant impairments in systems of meaning, interpersonal relationships, and somatization in 24-42% of a sample of war and genocide survivors. The DSM-IV's restriction of PTSD's diagnostic criteria to essential

features dismisses many of these characteristics and manifestations of responses to traumatic stress. As argued by Brett (1996), these manifestations remain important as they have clinical and treatment relevance for the chronically traumatized. According to Kira and colleagues (2006), the PTSD model "cannot account for the severity or the serious multilateral effects of torture or other cumulative or complex traumas" (p. 211).

Clinicians working with this unique population find that PTSD de-emphasizes somatic complaints, dissociative symptoms, and personality disturbances in favor of symptoms that fit neatly into its core criteria (i.e., re-experiencing, hyperarousal, and avoidance). They find that victims are often difficult to identify due to high levels of somatization, considerable comorbidity, and developmental deficits associated with their posttraumatic reactions to torture (Grodin et al., 2008; Schubert & Punamaki, 2011). These issues are confounded by refugees' fear of disclosure, feelings of shame and survivors' guilt, lack of trust for providers, and a tendency to manifest distress in ways that are incongruent with Western culture (Blaz-Kapusta, 2008; Chester & Holtan, 1992; Chung, 2001; Regel & Berliner, 2007). In light of these limitations, some are even in support of the use of a separate torture syndrome among refugee survivors, as this may establish more flexible criteria and a better diagnosis of the psychological difficulties associated with torture (Whittaker, 1988).

One of the major criticisms of PTSD's applicability to refugee populations has centered on the fact that its study was based exclusively on the post-trauma experiences of white male Westerners between 1895 and 1974 (van der Kolk, Weisaeth, & van der Hart, 1996). Its position in the psychiatric world became solidified when it was effectively used to address the severe psychiatric problems of returning Vietnam veterans

in the seventies. According to Nicholl & Thompson (2004), this diagnostic framework remains value-based, culturally-biased, and widely influenced by the historical, social, and economic factors that were in play during that era. It is increasingly regarded as a system that lends itself to treatment exclusively focused on specific symptom reduction and response severity (Nicholl & Thompson, 2004). Despite its many successes in the diagnosis and treatment of traumatized individuals, it does not fully account for the range of symptoms experienced by non-Westerners and people of color. As argued by Lears & Abbotts (2005), PTSD symptoms among refugees differ according to their culture, and their symptoms often take the form of somatic complaints that are culturally determined. Several investigators (e.g. Summerfeld, 1999; Watters, 2001) note that PTSD's essential flaw is its biomedical approach to psychopathology that is based on Cartesian dualism, which makes it nothing more than a "socio-political pseudocondition" that reframes suffering into a technical problem to which short-term technical solutions (e.g., counseling, medication) can be applied (p. 1061).

Factor analytic studies on PTSD have shown that PTSD's three-factor model (i.e., avoidance, re-experiencing, and arousal) can look quite different when applied to varying groups of traumatized refugees and non-Westerners (Rasmussen, Smith, & Keller, 2007; Vincent and Chang, 2012). Among the many problems cited is the inclusion of avoidance and numbing on the same domain (Criterion C), which appears to manifest itself differently among certain ethnic groups (Rasmussen et al., 2007). In one particular sample of African refugees exposed to political violence, investigators found that symptoms of intrusion and hyperarousal were nearly indistinguishable. Moreover, research suggests that PTSD places great emphasis on phenomenological diagnoses,

while discounting the important interplay between biological and psychological processes, and between the trauma symptoms themselves (van der Kolk and McFarlane, 1996). Ultimately, these issues make the identification and treatment of trauma symptoms more challenging for counselors, who will increasingly encounter unprecedented numbers of refugee torture survivors in their line of work (Marotta, 2003).

Disorders of Extreme Stress Not Otherwise Specified (DESNOS)

In contrast to the documented weaknesses of the PTSD, DESNOS offers a clinically relevant classification system to frame the posttraumatic stress reactions of refugee torture survivors (Herman, 1992). This framework consists of seven areas of functioning, all of which are involved in the posttraumatic stress reactions of refugees exposed to chronic trauma (Blaz-Kapusta, 2008). Termed "alterations", the degree to which these areas are impaired have been associated with a number of factors, including duration of trauma, number of exposures, age of onset, and cultural and religious background, to name a few (van der Kolk et al., 2005). The following outline summarizes the diagnostic criteria for DESNOS:

DESNOS Diagnostic Criteria

I. Alteration in affect and impulse regulation
    a. Required: Difficulty regulating affect.
    b. At least one of the following required: Self-destructive behavior, suicidal preoccupation, difficulty modulating anger, or sexual risk-taking behaviors.

II. Alteration in attention and consciousness:

a. Either of the following required: Amnesia or transient dissociative episodes/depersonalization.

III. Alteration in self-perception:

a. At least two of the following required: Feelings of ineffectiveness, guilt, permanent damage, shame, minimization, or feeling misunderstood.

IV. Alteration in interpersonal relationships:

a. At least one of the following required: Inability to trust, re-victimization, or victimization of others.

V. Alteration in perception of perpetrator:

a. Common features, but none of the following required: Idealization of perpetrator, preoccupation with harming perpetrator, or distorted beliefs about perpetrator.

VI. Somatization:

a. At least two of the following required: Digestive problems, chronic pain, cardiopulmonary symptoms, conversion symptoms, or sexual dysfunction.

VII. Alteration in systems of meaning:

a. At least one of the following required: Despair and hopelessness, loss of previously-held beliefs.

Note: DESNOS diagnostic criteria. Adapted from "Disorders of extreme stress: The empirical foundation of a complex adaptation to trauma" by B.A. van der

Kolk, S, Roth, D. Pelcovitz, S. Sunday, & J. Spinnazola, 2005, *Journal of Traumatic Stress, 18*(5), p. 389-399.

Unlike PTSD, DESNOS provides consideration for the pervasive disturbances in perception, affect regulation, personality development, and impulse control that often occur in response to severe and prolonged traumatization among survivors of torture (Liebenberg & Papaikonomou, 2010; Luxenberg, Spinazzola, & van der Kolk, 2001). Most studies on DESNOS to date have applied this framework to war veterans (Ford, 1999; Jongedijk, Carlier, Shreuder, & Gersons, 1996), battered women (Blaz-Kapusta, 2008), victims of child abuse (Cloitre, Stolbach, Herman, van der Kolk, Pynoos, Wang, Petkova, 2009), low income women (Ford, 1998), sex workers (Choi, Klein, Shin, and Lee, 2009), hostages (Cantor and Price, 2007), victims of sexual abuse (Miller and Resick, 2007), and college women (Ford et al., 2006). Very little is known about the applicability of DESNOS to non-Western people of color (de Jong, Komproe, Spinazzola, van der Kolk, and Van Ommeren, 2005).

Although there is some overlap between PTSD's focus on avoidance and hyperarousal symptoms and DESNOS' focus on affect and impulse dysregulation, as it stands, the current PTSD criteria does not take into account a host of other traumatic stress symptoms commonly reported among torture survivors. For instance, PTSD is an anxiety disorder, while DESNOS criteria include broader impairment in cognitive, affective, relational, and biological self-regulation (Ford et al., 2006). Among survivors, this may manifest itself as dissociative episodes, mood disturbances, or interpersonal problems. A study conducted among Kosovar civilian war victims found that independent

of the effects of PTSD, DESNOS was significantly associated with poorer psychological functioning, satisfaction with life, and social support (Morina & Ford, 2008). The DSM-IV's restriction of the diagnostic criteria of PTSD to essential features dismisses many of these characteristics that have clinical and treatment relevance for the chronically traumatized (Brett, 1996). Though the American Psychiatric Association warns against the strict adherence to the PTSD criteria, many clinicians continue to operate as though the criteria is a complete and exact description of the disorder (APA, 1994; Brett, 1996).

Another reason that DESNOS should be used in the conceptualization of torture trauma among refugees is that its treatment differs from the treatment of PTSD among some samples. Many clinicians working with this population have reported several challenges in the implementation of therapeutic interventions (Regel & Berliner, 2007). Blaz-Kapusta (2008) argues that while PTSD psychotherapy interventions must focus on the direct psychological consequences of trauma exposure and trauma memories, DESNOS psychotherapy interventions must focus on treating the "present trauma", which includes current symptoms and their impact on various areas of current functioning. As opposed to challenging a refugee survivor to emotionally process a traumatic memory, the focus would be on strengthening their ability to regulate their emotions or resolve their interpersonal problems.

Though diagnosis may be difficult due to DESNOS' lack of core symptoms and numerous diffused ones, researchers argue that it is essential that a distinction be made between simple PTSD and DESNOS to ensure treatment is comprehensive and integrative (Jongedijk et al., 1996). Others argue that a phase-oriented sequential approach focused on alliance formation and stabilization, trauma processing, and

functioning reintegration is essential to improve prognosis (Ford, Courtois, Steele, van der Hart, & Nijenhuis, 2005).

Applicability of DESNOS to Refugee Torture Survivors

DESNOS accounts for the three broad areas of disturbances commonly found among survivors of complex traumas; namely symptomatic, characterological and vulnerability to repeated harm (Herman, 1993). DESNOS' first area of functional impairment, affect and impulse dysregulation, is characterized by poor modulation of aggression, labile affect, and extreme emotional reactions, such as rage or sadness, that are inappropriate to the situational context (Blaz-Kapusta, 2008). Studies show that refugee survivors present with significant mood disturbances characterized by pervasive sadness, mania, fear, anger, rage, emotional lability, and difficulty coping with daily emotional stressors (Chester & Holtan, 1992; Hougen, Kelstrup, Petersen, & Rasmussen, 1988). This is consistent with the research findings of DESNOS, which suggest that individuals who meet criteria for this disorder tend to be easily overwhelmed, over-react to emotional stressors, have difficulty self-soothing, and engage in self-destructive behaviors to manage distressing emotional experiences (Luxenberg, et al., 2001). Impulsivity, a hallmark of DESNOS, involves self-injurious behaviors ranging from self-mutilation and eating disorders to suicidal preoccupation (Blaz-Kapusta, 2008). One study among tortured and traumatized refugees from various countries found a high prevalence of suicidal attempts and up to 50% of subjects reported engaging in suicidal behavior (Ferrada-Noli, Asberg, Ormstad, Lundin, & Sundbom, 1998). Self-injury and suicidal preoccupation are symptoms that are adequately addressed within DESNOS but de-emphasized by PTSD.

The second area of functioning in DESNOS involves an alteration in the chronically traumatized person's attention and state of consciousness. As per Herman (1993), these alterations include experiences of amnesia, depersonalization, and transient dissociative episodes that assist in altering an unbearable reality. According to this framework, the chronically traumatized may rely more heavily on dissociative coping strategies, such as absorption/fantasy and depersonalization/derealization to manage distress. Among refugee torture survivors, dissociation remains an insufficiently recognized symptom under PTSD, but is a key feature of complex posttraumatic reactions. Chester & Holtan (1992) also note the high prevalence of memory deficits, problems with concentration, confusion, and other areas of cognitive functioning in this population. One particular study among African refugee torture victims found that a majority of subjects reported mild to moderate difficulty managing daily tasks and solving complex problems (Bandeira, Higson-Smith, Bantjes, & Polatin, , 2010). Moreover, survivors of torture typically report peritraumatic dissociations involving impairment in awareness, perceptual changes, and emotional numbing, all of which help to ease pain and manage distress (Lueger-Schuster, 2010). Studies among refugee torture survivors from the Middle East, Asia, Africa, Latin America, and the Balkan regions of Eastern Europe revealed that 6% met diagnostic criteria for dissociative disorders (Ferrada-Noli et al., 1998). Unlike the current PTSD classification system, DESNOS allows for the further assessment of dissociation, including depersonalization and derealization, among this unique population. As per Briere & Spinazzola (2005), these strategies often serve the function of reducing emotional distress during a traumatic

event, as well as reducing the emotional response at a later time when memory of the event is triggered (Briere & Spinazzola, 2005).

The third area of functioning in DESNOS involves alterations in self-perception. According to Herman (1993), victims of prolonged interpersonal trauma involving coercive control often experience profound fragmentation and alterations in their self-concept. This may include feelings of guilt, shame, hopelessness, or of being ineffectual, permanently damaged, undesirable to others, or at fault for one's own trauma (Blaz-Kapusta, 2008; Luxemberg et al., 2001). When applied specifically to refugee torture survivors, changes in self-perception following torture is a commonly reported symptom. Shame, guilt, humiliation, and fear of being permanently damaged remain a major psychological issue for refugee torture survivors (Shapiro, 2003). Survivors often harbor feelings of being devalued by their torture, including feelings of helplessness due to their inability to resist/defend against the torturer's acts (Shapiro, 2003). Other studies among tortured and traumatized refugees found that subjects with a history of military/political involvement were likely to report feelings of guilt for having survived while their significant others or comrades were either killed or left behind (Ferrada-Noli et al., 1998; Gorman, 2001). Additional changes in self-perception involve feelings of inadequacy and of being ineffectual. A study among refugee torture survivors in South Africa found that on average, subjects scored significantly lower, compared to nontortured samples, on measures of Self-Perception and Functioning and had the tendency to endorse negative perceptions of their capacity to meet the challenges of everyday life (Bandeira et al., 2010). This was found to be especially true among male torture survivors. Hence, changes in a refugee's self-concept and self-regard following torture exposure must also

be assessed prior to diagnosis and treatment. Herman (1993) refers to these deficits in self-perception as a "complex deformation of identity" in which they perceive themselves as contaminated or inherently evil.

The fourth functional impairment that allows for the diagnosis of DESNOS involves victims' perception of their perpetrator. PTSD does not specifically account for the impact of torture on victims' perception of their torturer, and the effects of these perceptions on functioning. Many DESNOS victims find themselves preoccupied with feelings of revenge, anger, or even rage as it relates to their perpetrators. Studies among refugee survivors have found that feelings of hate and revenge are commonly reported among subjects and that facile pronouncements of forgiveness were common coping strategies (Cardoza, Kaiser, Gotway, and Agani, 2003; Stepakoff, Hubbard, Katoh, Falk, Mikulu, Nkhoma, & Omagwa, 2006).

The fifth area of functioning affected by prolonged exposure to trauma is social relationships. Studies among chronically traumatized patients have found significantly higher rates of interpersonal problems, social avoidance, and other relationship disturbances as compared to patients without trauma history (Spitzer, Barnow, Wingenfeld, Rose, Lowe, & Grabe, 2009). According to this framework, individuals may also experience persistent distrust of others, self-isolation, become perpetrators that victimize others, or re-enact their traumas in their relationships (Blaz-Kapusta, 2008). Consistently, studies among refugee torture survivors reveal that feelings of betrayal are often experienced on a number of levels, resulting in a profound lack of trust for authority figures, community members, and even loved ones (Chester & Holtan, 1992). Studies among African refugee torture survivors found that a majority of subjects reported having

difficulty controlling their reactions to others, while nearly half reported having problems connecting to family (Bandeira et al., 2010). Findings from a study among tortured refugees resettled in Turkey revealed that perceived lack of social support from spouses, partners, family, and friends was predictive of anxiety and depressive symptoms (Basoglu, Paker, Ozmen, Tasdemir, & Sahin, 1994). These survivors typically report sexual dysfunction, fear of intimacy, social withdrawal, and other symptoms of social impairment (Gorman, 2001). These symptoms result in persistent self-isolation, distrust of others, patterns of re-victimization, or of becoming a perpetrator that victimizes others. Unlike PTSD, the DESNOS constellation allows for the further assessment and treatment of interpersonal/social impairment, a major barrier to recovery for refugee torture survivors (Ford et al., 2005).

The sixth area of functioning in DESNOS involves somatization. Chronically traumatized individuals often present with chronic physical complaints that defy medical explanation and are resistant to intervention. Clinicians have found that chronically traumatized patients who experience anxiety, hypervigilance, and agitation over time begin to endorse somatic complaints, such as tension headaches, abdominal discomfort, back and pelvic pain, nausea, and tremors (Herman, 1993). Studies conducted among survivors of prolonged captivity have found that somatic problems were nearly a universal complaint, as posttrauma reactions were expressed primarily in somatic terms (Herman, 1993). It is well-documented that for many cultures, somatic complaints serve as an idiom of posttraumatic distress when psychological dysfunction is stigmatized or not widely accepted (Briere & Spinazzola, 2005). Consistently, providers working with refugee torture survivors find that they are more prone to report physical symptoms,

rather than psychological or emotional, as their chief complaint (Chester & Holtan, 1992). This phenomenon is well-documented among cultures where psychological distress remains highly stigmatized, while physical illness or injury are viewed as the only socially acceptable complaint for trauma victims (McCullough-Zander & Larson, 2004). Several study investigators (e.g., Chester & Holtan, 1992; Tamblyn, Calderon, Combs, & O'Brien, 2011) note that specific somatic complaints typically involve areas of the body where the torture was applied, while vague/non-specific complaints are highly prevalent among victims of sexual torture. Other investigators report that despite the lack of evidence for physical cause or disease etiology, many refugee torture survivors commonly report hearing loss, headache, shoulder and back pain, gastrointestinal distress, and joint pain, (Goldfeld et al., 1988; McCullough-Zander & Larson, 2004).

Finally, the seventh area of functioning outlined by DESNOS involves systems of meaning. Individuals with a history of severe trauma often experience significant changes in previously held beliefs, as well as feelings of hopelessness, helplessness, and despair (Jongedijk et al., 1996; van der Kolk et al., 2005). They may experience changes in their religious or ethical belief structures, adopt a fatalistic approach to life, and develop a profound learned helplessness that inhibits them from making important decisions or changes in their lives. In a sample of 1,134 resettled East African refugees, a history of torture and trauma was found to be significantly associated with changes in religious practice, pre-existing beliefs, and helplessness (Jaranson et al., 2004). Moreover, this study revealed that subjects who maintained their religious ties following migration endorsed fewer trauma symptoms and experienced fewer social problems as compared to the nontortured and non-traumatized comparison group. Ferrada-Noli and colleagues'

(1998) study among refugee torture survivors found that a significant number of subjects reported feelings of despair and hopelessness following torture exposure. Given that these symptoms are highly associated with depression and suicidality among traumatized adults, they warrant consistent assessment among refugees.

Summary

DESNOS has been linked to varying types of interpersonal trauma exposure as its proponents argue that it better accounts for the complex symptomatology characterized by survivors of repeated traumatization (Jongedijk et al., 1996). To date, research on DESNOS has been primarily focused on its measurement and validity among Westerners, resulting in a dearth of knowledge on its presentation in non-Western samples (de Jong et al., 2005).

Despite the paucity of empirical research investigating the validity of DESNOS for non-Westerners, the diagnosis is particularly useful in conceptualizing and understanding the trauma reactions of refugee torture survivors. Refugee survivors of torture represent one of the most vulnerable and traumatized populations among us due to their prolonged and severe exposure to war, violence, displacement, and consecutive losses (Lears & Abbott, 2005). These victims may be very different from other trauma survivors, since their trauma often consists of a series of events that were deliberately applied over time, within the context of an interpersonal relationship, in order to elicit a desired psychological result (Velsen, Gorst-Unsworth, & Turner, 1996).

Several investigators point out that the DESNOS diagnosis is highly applicable to victims of long-term suppression and totalitarian control, a feature which is particularly relevant for refugee torture survivors, who are often held against their will for extended

periods of time and whose torture is often sanctioned by oppressive governmental regimes (Berliner et al., 2004; Jaranson et al., 2004; Punamaki, Qouta, & Sarraj, 2010; Thapa et al., 2003). As noted by Herman (1999), complex trauma occurs mainly within the context of captivity, when a victim is unable to flee or under the control of the perpetrator. According to Watters (2001), the PTSD label simply does not give voice to a refugee's own perception and interpretation of these torture experiences at the hands of others.

According to Jongedijk et al. (1996), those providing care to the chronically traumatized should focus psychotherapy on restoring trust in others and regaining stable reactions, rather than working through emotions. This was illustrated in a study among Cambodian refugees that showed that reprocessing traumatic memories was not very useful (Chung, 2001). Chung (2001) adds that counselors working with this population must, above all, be familiar with multicultural counseling competencies, develop a strong working alliance, promote self-empowerment, integrate traditional health methodologies, and understand the influence of culture in the conceptualization of mental health and PTSD in order to effectively treat this population.

Since its conception, DESNOS has been at the center of great controversy by theorists, researchers, and clinicians (Brett, 1996). Opponents of DESNOS as a separate diagnostic category argue that most individuals who meet criteria for DESNOS also meet criteria for PTSD and that DESNOS is essentially an "associated feature" of PTSD. This was supported by the findings of a study of adult survivors of childhood sexual abuse where 92% of the subjects met criteria for both disorders (Ford, 1999). However, later studies showed that not only did DESNOS appear independent of PTSD, its largest

degree of non-overlap was among trauma survivors who suffer the most extreme forms of pathological dissociation, affect dysregulation, and somatization (Ford, 1999). Extremely traumatized individuals were more likely to experience impairments in consciousness, affect, and impulse regulation rather than avoidance, hyperarousal, numbing, fear, and other hallmarks of PTSD. Clinical reports of women exposed to prolonged interpersonal violence, for example, showed that subjects suffering from DESNOS did not typically report psychological sequelae that are captured by the DSM-IV's PTSD diagnostic criteria (Choi, Klein, Shin, & Lee, 2009). A study of Vietnam War veterans who presented for PTSD treatment at a Veterans Administration hospital, found that DESNOS and PTSD were highly co-morbid but distinctly different diagnoses (Ford, 1999).

Despite the National Institute of Mental Health's DSM-IV field trials that confirmed its existence and frequency among trauma victims, DESNOS has yet to be recognized as a free-standing diagnosis within the current or proposed versions of the DSM (Brett, 1996; Bryant, 2010; Spitzer et al., 2009). Instead, the DESNOS symptom constellation is recognized as a non-specified disorder associated with posttraumatic stress and described under the DSM-IV's "associated and descriptive features" of PTSD (APA, 1994). Within the ICD-10, disorders characteristic of DESNOS are referred to as "Lasting Personality Changes following Catastrophic Stress" (Blaz-Kapusta, 2008).

Conclusions

As the number of survivors continues to grow in this country, counselors will increasingly encounter this vulnerable population in a variety of treatment settings, ranging from schools to government agencies (Marotta, 2003). Considering that a significant number of these refugees continue to develop symptoms of posttraumatic

stress, depression, anxiety, sleep disturbance, and somatic complaints even years after exposure to torture, it is imperative that counselors be knowledgeable and skilled in treating their unique patterns of psychological symptoms (Goldfeld et al., 1988; Grodin, et al., 2008; Hargreaves, 2002; Holmqvist et al., 2006; Jaranson et al., 2004; Lindencrona, Ekblad, & Hauff, 2008; Olsen et al., 2007). As demonstrated by Jongedijk and colleagues' (1996) study among Dutch war veterans, DESNOS is a distinct disorder with features that make it distinguishable from simple PTSD. Counselors must recognize the limitations of the current PTSD classification system, as it does not adequately reflect the diversity of symptoms elicited by prolonged exposure to trauma, such as torture, and leads to inadequate treatment interventions (Jongedijk et al., 1996). Above and beyond assessing refugee torture survivors for PTSD, counselors will need to be culturally-competent and willing to examine the impact of torture on a refugee's self-perception, system of meaning, physical well-being, relationships, and cognitive and affective functioning. Symptomatically, survivors of severe and prolonged trauma often look entirely different than those who experience singular, circumscribed events, such as rape, accidents, disaster, or combat (Herman, 1993). Characterologically, the chronically traumatized often experience personality disturbances that include deficits in their identity development and ability to relate to others. Additionally, they are found to have experienced an increased vulnerability to repeated harm, inflicted by themselves or others (Herman, 1993). Given the accumulating evidence that the PTSD diagnosis does not adequately account for the diversity of symptoms experienced by traumatized refugee torture survivors, this author contends that we must examine the applicability of DESNOS to this population.

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‘MEANS OF SURVIVAL’ AS MODERATOR OF THE RELATIONSHIP BETWEEN CUMULATIVE TORTURE EXPERIENCES AND POSTTRAUMATIC STRESS DISORDER AMONG REFUGEES

Introduction

The aim of the present study was to examine the association between torture exposure and posttraumatic stress symptoms, as moderated by coping, among a sample of adult refugee survivors of torture. Evidence suggests that between 5% and 35% of refugees who present in resettlement camps and treatment centers around the world are victims of torture (Jaranson, Butcher, Halcon, Johnson, Robinson, Savik, Spring, & Westermeyer, 2004). Torture is defined as any act that involves the use of severe pain or suffering, whether physical or psychological, that is intentionally inflicted upon a victim for the purposes of punishment, obtaining information, discrimination, or intimidation/coercion, by a public official or person acting in official capacity (UNCAT, 1985). According to Marotta (2003), the ultimate purpose of torture is to “break the spirit of individuals or groups through systematic application of painful physical or mental procedures” (p. 111). Recent reports show that cruel, inhuman, and degrading torture practices are routinely used by contemporary regimes around the world, despite the 1955 ratification of the Geneva Conventions that made the use of torture a war crime (McCullough-Zander & Larson, 2004; Punamaki, Qouta, & Sarraj, 2010). The use of torture remains a global public health problem that has long-standing impact on individuals, families and communities (Grodin, Piwowarczyk, Fulker, Bazazi, & Saper, 2008), and even those who treat survivors (Marotta, 2003). With nearly half a million

refugee torture survivors in the US, counselors are increasingly likely to encounter this unique population in clinical practice (Gorman, 2001; Newall, 2007).

According to Gong-Guy and colleagues (1991), refugee survivors of torture often present with a myriad of psychosocial problems and challenges stemming from their exposure to torture and other pre- and post-settlement experiences. Studies show that they suffer from high rates of psychoses (Kroll, Yusuf, & Fujiwara, 2011), somatic complaints and chronic pain (Goldfeld, Mollica, Pesavento, & Faraone, 1988; Punamaki, Qouta, & El Sarraj, 2010), substance abuse (Holmqvist, Anderson, Anjum & Alinder, 2006), depression (Ellis, MacDonald, Lincoln, & Cabral, 2008), anxiety symptoms (Sachs, Rosenfeld, Llewa, Rasmussen, & Keller, 2008), dissociative disorders (Thapa, Van Ommeren, Sharma, de Jong, Hauff, 2003), and impaired memory (Gorman, 2001). It is even estimated that between 16-37% of refugee survivors of torture suffer from lifetime posttraumatic stress disorder (PTSD) (de Jong et al., 2001). PTSD is a chronic condition that involves the re-experiencing of traumatic events, heightened arousal, avoidant behaviors and emotional numbing that inhibit normal functioning (Jaranson et al., 2004; Ford, Stockton, Kaltman, and Green, 2006).

Research suggests that a significant number of refugees continue to develop symptoms of posttraumatic stress, depression, anxiety, sleep disturbance, and somatic complaints even years after exposure to torture (Grodin, et al., 2008; Hargreaves, 2002; Holmqvist et al., 2006; Jaranson et al., 2004; Lindencrona, Ekblad, & Hauff, 2008; Olsen, Montgomery, Bojholm, & Foldspang, 2007). These traumatic experiences are a major burden on the lives of refugees and carry an enormous cost to society when left unaddressed.

It is well-documented that torture exposure not only has significant impact on refugee psychosocial functioning, but has deleterious effects on their capacity to resettle and integrate into a new society (Grodin et al., 2008). Refugee victims of torture will experience significant levels of distress and a plethora of social difficulties stemming from resettlement, as compared to voluntary immigrant groups (Schweitzer, Melville, Steel, & Lacherez, 2006). Exacerbating their trauma symptoms, refugees must deal with a host of adverse issues, including ongoing uncertainty regarding their temporary status and residence, subjection to degrading bureaucratic acts and social aid, isolation, xenophobia, and lack of access to adequate medical and psychological care (Wenk-Ansohn, 2007). Additionally, refugees resettled in the West must grapple with post-migration stress, including social and economic strain, discrimination, acculturation, status loss, and prolonged separation from family and loved ones (Kira, Templin, Lewandowski, Clifford, Weincek, Hammad, Mohanesh, & Al-haidar, 2006; Lindencrona, Ekblad, & Hauff, 2008).

It is estimated that roughly 400,000 to 500,000 refugee torture survivors reside in the United States alone (Gorman, 2001; Newall, 2007). Determining the exact number is made difficult by the frequent reluctance of refugees to disclose such experiences due to shame, fear of legal consequences for themselves or families left behind, distrust, fear of stigma, or guilt associated with having survived (Blaz-Kapusta, 2008; Chester & Holtan, 1992; Chung, 2001; Regel & Berliner, 2007). It is also well documented that many torture survivors find it difficult to identify care providers and health professionals who are adequately trained and willing to attend to their torture stories (Goldfeld et al., 1988; Gorman, 2001). Considering that torture exposure is associated with a number of

psychological and medical problems, it has become essential that providers be knowledgeable and skilled in identifying the factors involved in the development of posttraumatic stress reactions in this population (UNHCR, 2008; Kanninen, Punamaki, & Qouta, 2002). As the number of survivors continues to grow in this country, mental health providers will increasingly encounter this vulnerable population in a variety of treatment settings, ranging from schools to government agencies (Marotta, 2003).

Several studies among refugees have noted the importance of coping behaviors and beliefs in the amelioration of psychological distress, improved quality of life, and positive therapeutic outcomes (Brune, Haasen, Krausz, Yagdiran, Bustos, & Eisenman, 2002; Schweitzer, Melville, Steel, & Lacharez, 2007). One study among 141 traumatized refugees demonstrated that having firm religious and political belief systems served as a protective buffer against PTSD (Brune et al., 2002). Coping refers to the cognitive and behavioral efforts to master, reduce, or tolerate exposure to an internal and/or external demand that is created by a stressful situation (Folkman & Lazarus, 1980). As argued by a number of investigators (e.g., Zautra & Wrabetz, 1991; Ghazinour, Richter & Eisemann, 2003), coping plays a critical role in shaping the meaning of traumatic life events and the impact of these stressors on functioning. According to Kanninen, Punamaki, & Qouta (2002), understanding a torture survivor's coping efforts is important in treatment, because these efforts can be directed towards more adaptive ways of dealing with their trauma memories.

Why certain individuals develop lasting symptoms as a result of traumatic life events, while others do not, has increasingly become a central focus in the field of trauma research (Van der Kolk, McFarlane, & Weisaeth, 1996). Among refugee torture

survivors, social support, religion, and political beliefs are the most commonly reported cognitive and/or behavioral strategies and have been shown to be associated with psychological distress (i.e., depression, anxiety, somatization, and posttraumatic stress disorder [PTSD]) (Brune et al., 2002). Studies show that social support, defined as the exchange of resources intended to enhance the well-being of a recipient, has been negatively associated with depression and somatic symptoms among refugee survivors of torture (Emmelcamp, Komproe, Van Ommeren, & Schagen, 2002; Gerritsen, Bramsen, Deville, van Willigen, Hovens, & van der Ploeg, 2006). Other investigations have determined that religious beliefs and political conviction, in addition to strong social supports, serve as protective factors against PTSD among refugee torture victims (Basoglu, Paker, Paker, Ozmen, Marks, Incesu, Sahin, & Sarimurat, 1994). This was evidenced in a large-scale study among 769 Tibetan refugees that revealed that psychological distress increased significantly with greater trauma exposure, and that religious practice, seeking social support, and other direct action strategies mediated the effects of between these two variables by diminishing psychological distress (Sachs et al., 2008).

Studies on the different types of refugee torture experiences have typically differentiated between three categories; physical assault, psychological abuse, and war-related trauma (Hooberman, Rosenfeld, Lhewa, Rasmussen, & Keller, 2007; Shrestha, Sharma, Ommeron, Regmi, Makaju, Komproe, Shrestha, & de Jong, 1998). Physical assault includes acts such as burning, hanging, forced standing, asphyxiation, and electric shock; while psychological torture includes death threats, humiliation, solitary confinement, sensory deprivation, and being forced to witness violence (Berliner,

Mikkelsen, Bovbjerg, & Wiking, 2004; Punamaki, Qouta, & Sarraj, 2010). War-related trauma, on the other hand, involves acts that are not solely directed at the individual, but target groups of people more broadly. Examples may include exposure to combat or war, cutoff to food and water supplies, disappearances of loved ones, and displacement. On the other hand, the Chilean Human Rights Commission has identified at least eighty-five different types of physical torture alone (Berliner et al., 2004). Despite the distinctions made between these categories, evidence suggests that the consequences of torture are broad and overlapping, and that regardless of torture type, many of the same psychological repercussions may be elicited (Hooberman et al., 2007). Though research has shown a clear association between torture and PTSD symptoms, there exist no research studies to date on the effect of *varying types of* torture on PTSD symptoms as moderated by coping among refugee survivors.

To date, only one study that was conducted among 62 newly-arrived Vietnamese ex-political torture survivors demonstrated a strong dose-effect relationship between cumulative torture experiences (the number of torture types) and PTSD arousal symptoms (Mollica, McInnes, Pham, Smith, Murphy, & Lin, 1998). In this sample, researchers found that the more types of torture experienced (dose), the more psychological distress (effect) was endorsed among refugees. Although not limited to torture, another study among Iraqi refugees by Kira and colleagues (2008) demonstrated that exposure to ongoing traumas (e.g., displacement, natural disasters, violence, etc) had the same cumulative (dose) effect on posttraumatic stress. According to Quiroga and Jaranson (2005), future research needs to explore the mental health effects of torture and

refugee trauma and examine how various traumatic stressors associated with these events interact in producing symptoms commonly observed in this population.

The present study examined the association between torture exposure and posttraumatic stress symptoms among a sample of 326 adult refugees. The moderating effect of 'means of survival' (the resources subject drew upon to cope with torture) on the relationship between cumulative torture experiences (the number of torture types) and posttraumatic stress disorder (PTSD) symptoms were analyzed. Consistent with the literature, the study investigator hypothesized that exposure to a greater number of torture types would be significantly associated with increased PTSD symptom severity and that the relationship between cumulative torture experience and PTSD would be buffered by means of survival among this sample. That is, the more means of survival coping processes endorsed, the weaker the relationship between cumulative torture experiences and posttrauma symptoms. This hypothesis is consistent with Mollica and colleagues (1998) finding of a strong dose-effect relationship between cumulative torture experiences and PTSD, and Sachs et al.'s support of the moderating role of coping in the relationship between torture and trauma.

Method

Participants

The study sample consisted of 326 adult torture survivors who presented for services between April 2008 and September 2009 at a refugee resettlement agency located in the Midwest. Participants were defined as refugees in accordance to UNHCR's 1951 criteria that they were persons who are outside their country of national origin and are unable or unwilling to return due to a well-founded fear of persecution, for reasons of

race, religion, nationality, social group or political opinion (UNHCR, 1951). Study participants presented at the resettlement agency for case management and social services support, assistance with immigration, employment/educational support, family counseling, and outreach services. Following the initial intake, trained interviewers screened subjects for enrollment eligibility, obtained informed consent, collected sociodemographic information, administered measures of posttraumatic stress and cumulative trauma disorders, and documented detailed accounts of all reported torture experiences. Each interview took approximately two hours to complete and was conducted in the native language of the participant. All participants reported exposure to one or more torture methods prior to displacement.

Measures

Dependent Variable

The Clinician Administered PTSD Scale (CAPS-2) was used to assess PTSD symptom severity among study subjects (Weathers, Keane, & Davidson, 2001). This 18-item instrument consists of four subscales designed to measure re-experiencing, avoidance, arousal, and dissociation/numbness (DSM-IV diagnostic criteria for PTSD). Subjects were asked to rate the frequency and severity of their PTSD symptoms within the past week on a 5-point Likert scale (ranging from 0 “not at all” to 5 “more than once/day”). The total severity score was summed and interpreted according to the following scale: 0–19 = asymptomatic/few symptoms, 20–39 = mild PTSD/sub-threshold, 40–59 = moderate PTSD/threshold, 60–79 = severe PTSD symptomatology, and >80 = extreme PTSD symptomatology. A cut-off total score of 26 was sufficient to be classified as presenting with PTSD symptoms (Kira et al., 2008). The instrument

yielded excellent inter-rater reliability (alpha .92 to .99.), high internal consistency (alpha .73 to .85), good discriminant validity, and in regards to convergent validity, correlated strongly with other standardized measures of PTSD (alpha .70 to .84)(Weathers et al., 2001).

Independent Variable

Data collected from the Torture Severity Scale was used to evaluate Cumulative Torture Experiences (CTE) among study subjects (Kira, Lewandowski, Templin, Ramaswamy, Ozkan, Hammad, & Mohanesh, 2006). This 16-item self-report instrument was modified from a form developed by Survivors International to measure torture. CTE measures the frequency of exposure to torture acts. Respondents are asked to report the number of times they were jailed and tortured, or suffered exposure to beatings, electric shock, burnings, upside down suspensions, suffocation, penetration, rape, and other forms of abuse. It categorizes these torture experiences into six subcategories (i.e., witness torture, physical torture, sexual torture, loss control of basic life routine, aggressive environmental control, and formal accusation). The sum of torture types endorsed was used to calculate CTE score. The higher the score on this instrument indicated the higher the severity of exposure to torture (i.e., higher the number of different types of torture endured). According to Kira and colleagues (2006), the measure yielded good reliability (alpha .87), and good concurrent convergent, divergent, predictive, and construct validity.

Moderating Variables

The Means of Survival Scale (MOS) is a 16-item measure of the types of strategies utilized during a subject's exposure to torture (Kira, 2012). These items represent a host of resources/areas of strength that the subjects drew upon to cope with

their torture trauma. Subjects were asked to respond to the question "what helped you to survive your torture?" and presented with a list of sixteen coping processes that included, luck/chance/fate, desire for revenge, humor/irony, cellmates, cooperation with torturers, deception of torturers, emotional distancing, physical exercise, forgiveness, or community/party/tribe support. Subjects were asked to answer affirmatively (an answer of 'yes') to the strategies that were utilized. For the present study, only four items from the MOS were examined as moderating variables (i.e., religious beliefs, family support, will to survive, political beliefs). Studies demonstrate that these are the most commonly reported cognitive and/or behavioral strategies utilized among refugees (Brune et al., 2002).

Demographic data was also collected as part of the intake process. These variables included age, gender, years of education, marital status, ethnicity, current residency status, previous occupation, length of stay in host countries, and religious affiliation.

Data Analysis

A power analysis was initially conducted utilizing Fauld, Erdfelder, Lang, and Buchner's (2007) GPower program for the social, behavioral and biomedical sciences. This program assessed the ideal sample size needed to detect a medium effect of $f2 = .15$ for the interaction effects, as recommended by Cohen (1992). A sample size of 116 was calculated to detect a significant effect size with a power of .90, alpha of .05, and a medium effect size of .15. This size was sufficient to adequately test for the individual moderation effects of family support, political beliefs, religious beliefs, and will to survive (MOS items) on the relationship between CTE and PTSD. A Bonferroni

adjustment, for multiple-comparison corrections, was performed and determined to be 0.0125, using the .05 p-value.

Participant characteristics (age, gender, ethnicity, country of origin, marital status, and educational attainment) were analyzed using descriptive statistics, including frequencies, measures of central tendency (i.e., mean, mode, median), standard deviations, and quartile ranges. Responses on the CAPS-2 and TSS were analyzed as interval data, while the MOS was analyzed as dichotomous and interval variables. The association between torture exposure and PTSD symptom severity was analyzed using Pearson/Point-biserial correlations.

Hierarchical multiple regression was performed to test the moderating effect of family support, religious beliefs, political beliefs, and the will to survive on the relationship between CTE and PTSD symptoms. According to Leech, Barrett, and Morgan (2011), this level of analyses is most appropriate when the relationship between the predictor and dependent variables are linear, and errors or residuals are normally distributed and uncorrelated with the predictors. For the present study, four separate regression analyses were conducted to determine the main and interaction effects of the predictor (CTE) and each of the hypothesized moderators (family support, religious beliefs, political beliefs, and will to survive) on PTSD symptoms. CTE and each of the moderators were entered into the first block. To reduce multicollinearity, CTE and the moderator variables were standardized into z-scores. Interaction terms were then created by taking the product of CTE and each of the moderators. The interaction terms were entered into the second block of the model to determine whether the interaction accounted for significant variation in PTSD symptoms. Figures 1-4 graphically depict the

hypothesized moderator models. According to Baron and Kenny (1986), when the effect of the independent variable and moderator variable are controlled, a significant interaction effect suggests a significant moderation. Only significant interactions were interpreted. All analyses were conducted between June and August 2012 using IBM SPSS Statistics 20.

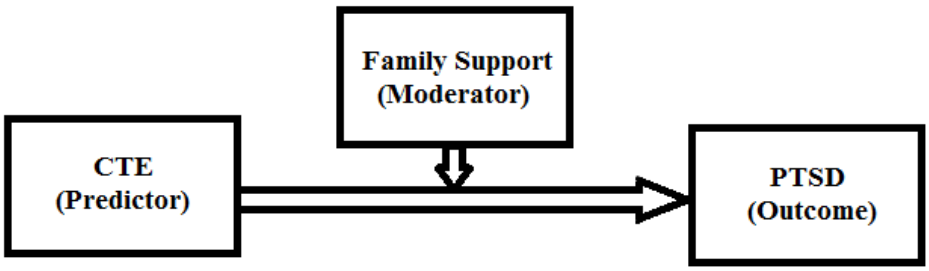

Figure 1. Family Support as Moderator

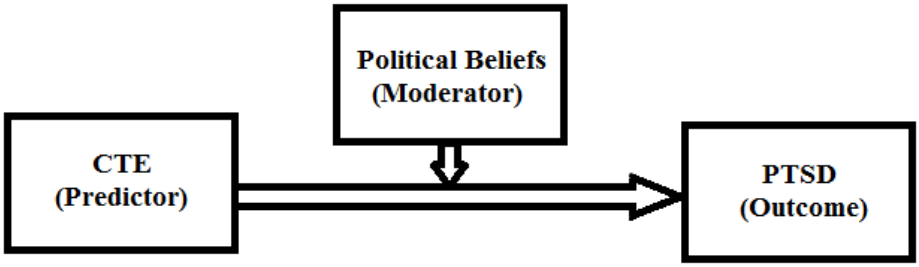

Figure 2. Political Beliefs as Moderator

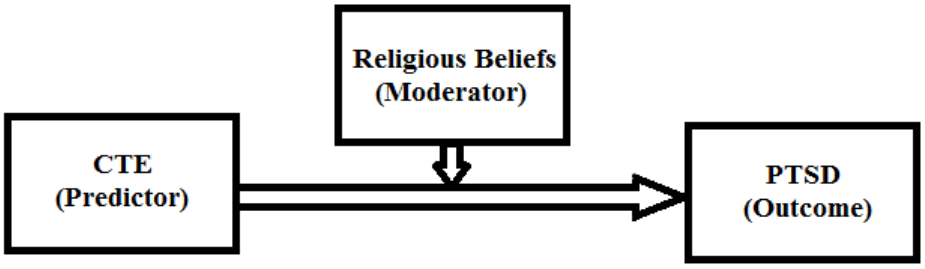

Figure 3. Religious Beliefs as Moderator

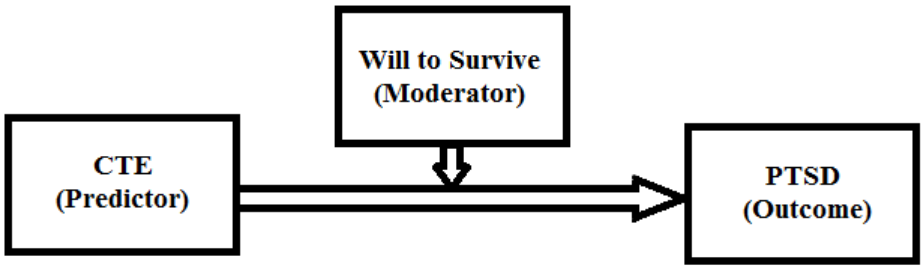

Figure 4. Will to Survive as Moderator

Results

Demographic Variables

All study participants were torture survivors who presented for services at a resettlement agency located in the Midwest. Ninety-five percent of the sample were refugees, and the remaining 5% consisted of asylees and U.S. citizens. Refugees are persons who are outside their country of national origin and are unable or unwilling to return due to a well-founded fear of persecution, for reasons of race, religion, nationality, social group or political opinion (UNHCR, 1951). The mean age for participants was 38.55 (*SD* = 11.59) years with a median of 37.5. All participants ranged between the ages of 18 to 76 years. Fifty-seven percent of the sample was male and 43% female and 65% were married. A majority of the participants self-identified as originating from Southeast Asia (47%), while the remaining represented countries in other regions of the world (25% Middle Eastern, 23% African, 2% Asian, 2% Caribbean, and less than 1% European and South American). Forty-five percent of those who disclosed their educational attainment had primary school education or less (*n* = 97). Information on participant characteristics is found on Table 1.

Table 1.
Participant Demographic Characteristics

Age	Frequency	%
18-25	48	14.7
26-35	87	26.7
36-45	112	34.4
46-55	51	15.6
56-65	22	6.7
66+	6	1.8
Gender		
Female	140	43
Male	186	57
Marital Status		
Single, never married	52	16
Married, living with spouse	212	65
Married, with spouse in native country	20	6
Divorced	7	2
Widowed	26	8
Spouse missing after displacement	7	2
Separated	1	<1
Cohabitating	1	<1
Educational Attainment		
No education	11	5
Primary school	86	40
Secondary school	60	28
Secondary school	58	27
*111 participants did not respond to item.		
Ethnicity		
Southeast Asian	153	47
Middle Eastern	82	25
African	75	23
Asian	7	2
Caribbean	7	2
European	1	<1
South American	1	<1

Descriptive Statistics

The MOS was used to measure the types of coping processes utilized during a subject's exposure to torture. These processes include religious beliefs, family support,

political beliefs and having the will to survive. Responses for each variable were coded either a "0" for "not utilized" or "1" for utilized. The mean number of processes reported was 1.5 (*SD* = .98). Fifty-one percent of the sample endorsed 2 or more of the items as means of survival. Consistent with the literature, religious beliefs were the most commonly reported strategy used to cope with torture (69%, *n* = 224), followed by family support (52%, *n* = 169), and will to survive (24%, *n* = 79). Contrary to the literature (Brune et al., 2002), political beliefs were utilized by the least amount of refugees in this sample (2%, *n* = 7).

The TSS was used to examine participants' self-reported cumulative torture experiences (the number of varying types of torture methods they endured). Responses were grouped into six subcategories (i.e., witness torture, physical torture, sexual torture, loss control of basic life routine, aggressive environmental control, and formal accusation). The sum of torture methods endorsed was used to calculate CTE score. The mean exposure to torture methods was 2.6 (*SD* = 2.2). Forty-five percent of the sample reported that they endured four or more different types of torture methods (*n* = 147). Table 2. shows the most frequent torture events reported.

Table 2.
Torture Types Reported

Subcategories	**%**
Witness torture	59.5
Physical torture	56.4
Sexual torture	36.5
Loss control of basic life routine	45.4
Aggressive environmental control	31.6
Formal accusation	30.4

The CAPS-2 was used to assess PTSD symptoms about study participants. CAPS-2 consists of four subscales designed to measure re-experiencing, avoidance, arousal, and dissociation/numbness (Weathers, Keane, & Davidson, 2001). A cut-off score of 26 was sufficient for clinically significant levels of post-trauma symptoms. Twenty-three percent (n = 74) of the sample reported clinically significant levels of PTSD symptoms. This prevalence is consistent with previous research findings of 16-37% PTSD diagnoses among refugee torture survivors (Jaranson et al., 2004).

Prediction and Association

As argued by Baron and Kenny (1986), when testing a moderator model the relationship between the moderating variable and both the independent and dependent variables must not be correlated above .80. This allows for a clear interpretation of the interaction terms. Correlations between CTE, each of the MOS items (family support, religious beliefs, political beliefs, and will to survive), and PTSD were analyzed in Table 3. The predictor and dependent variables were positively, though weakly, correlated, indicating that greater exposure to cumulative torture is associated with greater PTSD symptoms ($r[2] = .18$, $p<.01$). Weak positive correlations that were statistically significant were also found between PTSD and political beliefs ($r[2] = .13$, $p<.05$), PTSD and will to survive ($r[2] = .141$, $p<.05$), religious beliefs and will to survive ($r[2] = .15$, $p<.01$), and family support and will to survive ($r[2] = .130$, $p<.05$). Moderate positive correlations that were statistically significant were found between religious beliefs and family support ($r[2] = .33$, $p<.01$), and between will to survive and cumulative torture ($r[2] = .31$, $p<.01$).

Table 3.

Correlations between IV, DV, moderators	1	2	3	4	5	6
1. Posttraumatic Stress Disorder	1	.177**	.054	.051	.131	.141
2. Cumulative Torture Experiences		1	.099	.029	.091	.314**
3. Religious beliefs			1	.329**	.009	.150**
4. Family support				1	.100	.130*
5. Political beliefs					1	.064
6. Will to survive						1

**Correlation significant at the .01 level
*Correlation significant at the .05 level

Each of the four means of survival items (i.e., family support, religious beliefs, political beliefs, and will to survive) was tested separately as a moderator of the association between torture (CTE) and trauma symptoms (PTSD). Hierarchical regression analyses were performed to examine the significance of these moderators. The assumptions of linearity, normally distributed errors, and uncorrelated errors were checked and met. Interaction terms were created by calculating the product of each moderator with the independent variable (FAMSUP x CTE; RELBEL x CTE, POLIBEL x CTE; and WILL x CTE).

Results of the first regression analyses demonstrated that CTE (b=.12, p=.035) and political beliefs (b=.17, p=.002) were significant predictors of PTSD symptoms in this sample, R^2 = .039; F (2,323) = 7.55, *p*=.001. An examination of the moderating effect of political beliefs revealed that the interaction term (POLIBELxCTE) did not account for significant variation in PTSD symptoms, ΔR^2=.006; F (3,322) =5.72, *p* = .001. Political beliefs did not moderate the relationship between cumulative torture experiences and post-trauma symptoms.

The second regression analyses demonstrated that CTE and family support together predicted PTSD symptoms, R^2 = .028, F (2,323) =5.60, *p*=.004. Only 2.8% of

the variance in post-trauma symptoms can be explained by these variables. However, only CTE significantly contributed to the prediction model (b=.18, p=.001). The test for the moderating effect of family support revealed that the interaction terms (FAMSUPxCTE) did not account for significant variation in PTSD symptoms, ΔR^2=.004; F (3,322) = 4.23, p = .006. Family support did not moderate the relationship between cumulative torture experiences and posttrauma symptoms.

Results of the third regression analyses showed that CTE and religious beliefs together significantly predicted PTSD symptoms, R^2 = .027, F(2,323) = 5.47, p= .005. However, only CTE significantly contributed to the prediction (b=.17, p=.002). The test for moderation revealed that the interaction terms (RELBELxCTE) did not account for significant variation in PTSD symptoms, ΔR^2=.000; F (3,322) =3.664, p =.013. Religious beliefs did not moderate the relationship between cumulative torture experiences and posttrauma symptoms.

The final regression analyses revealed that CTE and will to survive together significantly predicted PTSD symptoms, R^2= .034; F (2,323) = 6.64, p=.001. Again, only CTE was found to significantly contribute to the prediction model (b=.15, p=.001). The test for moderation revealed that the interaction terms (WILLxCTE) did not account for significant variation in PTSD symptoms, ΔR^2=.003), F (3,322) = 4.80, p=.003. Will to survive did not moderate the relationship between cumulative torture experiences and post-trauma symptoms.

Discussion

The present study is the first of its kind to explore the moderating role of family support, political beliefs, will to survive, and political beliefs on the relationship between

exposure to varying torture types and posttraumatic stress reactions among refugee torture survivors. Findings confirmed the results of previous research by demonstrating the significant effect of cumulative torture experience on posttraumatic stress symptoms (Mollica et al., 1998). Results indicate that greater exposure to cumulative torture experiences (i.e., the number of varying types of torture endured by victims) is significantly, though weakly, associated with greater posttraumatic stress symptoms among this sample of refugee torture survivors. The present findings suggest that an examination of the cumulative effects of multiple exposures to torture is worth consideration in the development of treatment interventions for this unique population. As with Mollica and colleagues' (1998) study among tortured refugees, findings suggest that exposure to cumulative torture may play a role in the development of psychiatric symptoms. They found negative correlation between torture and re-experiencing and dissociation. Hence, a thorough evaluation of a refugee's torture history should include an assessment of the varying *types* of torture, in addition to the *degree* and *duration*.

It is worth noting that 23% (n = 74) of the sample endorsed clinically significant levels of PTSD symptoms. This prevalence is consistent with previous research findings of 16-37% PTSD diagnoses among refugee torture survivors (de Jong et al., 2001). The high incidence of PTSD in the present sample must be interpreted in light of prior findings that refugees are reluctant to disclose such experiences due to feelings of shame, distrust, guilt, stigma, and fear of legal consequences for themselves or families (Blaz-Kapusta, 2008; Chester & Holtan, 1992; Chung, 2001; Regel & Berliner, 2007). Considering that a significant number of these traumatized refugees continue to develop PTSD years after exposure to torture, and that symptoms have a significant impact on

their capacity to resettle and integrate into a new society, mental health providers must be knowledgeable and skilled in identifying and assessing the risk factors involved in the development of posttraumatic stress reactions in this population (UNHCR, 2008; Grodin et al., 2008; Kanninen et al., 2002).

The results of correlational tests revealed that greater exposure to cumulative torture was positively associated with greater PTSD symptoms. This supports the findings of prior studies on the dose-effect relationship between torture and poor mental health outcomes among refugees (Hollifield, Warner, & Westermeyer, 2011; Mollica et al., 1998). It was also found that having the will to survive was significantly correlated with greater endorsement of family support and exposure to different torture methods. These results may suggest that as victims are exposed to higher levels of torture, they rely on a greater diversity of coping processes to ameliorate their mounting distress. This complex interplay between torture exposure, trauma symptoms, and coping supports is consistent with Emmelcamp and colleagues' (2002) assertion that greater endorsement of coping strategies are positively associated with psychological distress (i.e., depression, anxiety, and somatic complaints). No moderating relationship was found for the MOS items (i.e., family support, religious beliefs, political beliefs, and the will to survive), with the relationship between torture exposure and PTSD. The lack of significant findings may be due, in part, to the use of the MOS items to capture coping processes utilized by subjects. A more validated instrument may have served as a better measure of this construct.

Although study data yielded some statistically significant results, it has several limitations and methodological flaws that compromise the utility of findings. The first

limitation involves the cross-sectional design of the study. Cross-sectional designs are limiting, because they make it more difficult to establish causal relationships from observational data. Additionally, the nonrandom recruitment of participants from a refugee resettlement agency weakens the generalizability of study findings. Convenience sampling may introduce selection bias (i.e., differences may exist between those who present for services and those who do not). There is also the possibility that social desirability and self-report bias may have influenced participant responses. As noted earlier, refugee torture survivors often grapple with stigma, shame, fear, and survivor's guilt, which has been shown to negatively impact disclosure rates. Participants may have responded to the items according to what they perceived as "socially acceptable" or legally safe responses. In addition, the measure of cumulative torture was not ideal, as it did not allow for the assessment of duration and intensity of torture. Finally, the study instruments were administered in the native language of each participant, introducing the possibility that items were not cross-culturally and conceptually equivalent. One example would be in the interpretation of the words "trauma", "depression", and "anxiety", which do not exist in certain African and Asian languages.

Implications

The present study has several important implications for mental health providers and caseworkers who treat refugees presenting at resettlement agencies. Firstly, the high prevalence of PTSD among this sample suggests that a thorough assessment of torture histories and current psychosocial functioning should be undertaken as a regular part of case management (Goldfeld et al., 1988; Kroll et al., 2011; Punamaki, Qouta, & El Sarraj, 2010). These refugees were greatly symptomatic, but very few have access to

ongoing mental health services. The present study also highlights the importance of examining exposure to varying torture methods as part of a refugee's treatment plan. As demonstrated, the number of different types of torture methods (e.g., starvation, sexual assault, beatings, etc.) is associated with the use of certain coping processes and post-trauma symptoms.

Why some survivors of torture develop PTSD symptoms while others do not continues to elude trauma researchers in the field. Though not fully understood, the present study showed that coping is associated with trauma symptoms among refugee torture survivors. A thorough understanding of a torture survivor's coping efforts may be important in treatment, because these efforts can be directed towards more adaptive ways of dealing with their trauma memories. Study results suggest that the relationship between torture, coping mechanisms, and symptoms is complex and requires further investigation. Future interventions for refugees may benefit from a focus on resiliency-enhancing factors and the effective use of adaptive coping skills among those exposed to multiple tortures.

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APPENDIXES

APPENDIX A

DEKALB COUNTY BOARD OF HEALTH
CENTER FOR TRAUMA AND TORTURE SURVIVORS (CTTS)
INTAKE FOR PRIMARY TORTURE SURVIVOR

Case Number_____
Place Sticker Here

☐ In QS ☐ Consent for Treatment ☐ HIPAA
☐ In CTTS Database ☐ Eligibility Checklist ☐ Release of Information

Client Name: _____ Date of Intake _____

Date of Birth _____ Age Now ____ Country of Origin _____

Gender: Male ☐ Female ☐ Date Enrolled in Program _____

PRIMARY SURVIVOR SECONDARY SURVIVOR
Circle one of these

DEMOGRAPHICS & BACKGROUND

1 Referred by (circle)
Self
Family or ethnic community
Attorney
Non-governmental organization
Religious organization
Physician or health care provider
Mental health provider
DeKalb County Board of Health
School or university
Other CTTS client
CTTS sub-contractor
Refugee Health DCBOH
Other _____

1.1.1 Health Insurance
☐1. None ☐ 2. Medicaid

☐ 3. Medicare ☐4. Group
☐ 5. Disability ☐ 6. _____

Referral Source Contact Information

Organization:

Person Name:

Phone: (___) ____ __-_____

Patient's Contact Information
Name of apartments:

Address:

Home: (___) ____ _____

Work: (___) ____ _____

Mobile: (___) ____ _____

Food Stamps Yes ___ No ___
TANF Yes ___ No ___

1.1.2 Geographical Area of Origin

1. Asia☐ 2. Australia☐ 3 Central America☐ 4. Caribbean☐
5. Europe☐ 6. Middle East☐ 7. North Africa☐ 8. Sub-Saharan Africa☐
9. North America☐ 10. South America☐

1.1.3 Marital Status

1. Married & together now☐ 2. Living with Partner ☐ 3. Never Married☐
4. Divorced ☐ 5. Widow/Widower☐ 6. Spouse is missing☐ 7. Spouse back home ☐ 8. Separated by Choice ☐

1.1.4 Number of Children:

1. Total: ___ # Natural ___ # Adopted ___ # Alive ____ # Dead ___ # Missing __
Males________ Females _______

Age *Name*	: Alive	Dead	Missing	With Ext Fam	Here Now	Male	Female
Child _________________	☐	☐	☐	☐	☐	☐	☐
Child _________________	☐	☐	☐	☐	☐	☐	☐
Child _________________	☐	☐	☐	☐	☐	☐	☐
Child _________________	☐	☐	☐	☐	☐	☐	☐
Child _________________	☐	☐	☐	☐	☐	☐	☐
Child _________________	☐	☐	☐	☐	☐	☐	☐
Child _________________	☐	☐	☐	☐	☐	☐	☐
Child _________________	☐	☐	☐	☐	☐	☐	☐
Child _________________	☐	☐	☐	☐	☐	☐	☐
Child _________________	☐	☐	☐	☐	☐	☐	☐
Child _________________	☐	☐	☐	☐	☐	☐	☐

1.1.5 Date of Arrival: mm/dd/yyyy ____/_____/_________

1.1.6 Current Immigration Status:

1.No documents ☐
2.Refugee ☐

3.Asylee ☐
4.Asylum seeker ☐
5.US Citizen/Perm.Res. ☐
6.Student Visa ☐
7.Tourist Visa ☐
8. Withholding remov ☐
9. TPS ☐
10.Other _____ ☐

1.1.7 Work Authorization: 1. No ☐ 2. Yes ☐
1.1.8 Total Years of Education: ____ years in **1.1.15** (country) _____
1.1.9 Highest Level of Education Completed:

☐1. Primary School ☐ 2. High or Secondary School ☐ 3. College

☐ 4. Post-Graduate ☐5. Technical Vocational School ☐ 6. None

1.1.10 Occupation:

1.Highest occupation held in country of origin: _____

_____ HURIDOCS code for highest occupation held in country of origin.

2. In the US: _____ Average Monthly Income After Taxes: $_____

_____ HURIDOCS code. Name of employer_____

1.1.11 Participating in ESL now? ☐1. Yes ☐ 2. No

1.1.12 Command of English Language: Interpreter needed during interview?
☐Yes ☐ No
0 = None
Name of Interpreter Used _____
1 = Great difficulty, single words
2= Some difficulty, construct sentences
3= Fluent
1.1.13a Other languages spoken: _____

	0	1	2	3
1. Speaks	☐	☐	☐	☐
2. Reads	☐	☐	☐	☐
3. Writes	☐	☐	☐	☐

1.1.13b Other languages spoken: _____

	0	1	2	3
1. Speaks	☐	☐	☐	☐
2. Reads	☐	☐	☐	☐

3. Writes ☐ ☐ ☐ ☐

1.1.14 Religious Preference:

☐1. Protestant ☐ 2. Catholic ☐ 3. Orthodox ☐ 4. Jewish ☐ 5. Buddhist ☐ 6. Hindu
☐7. Muslim Sunni ☐8. Muslim Shiite ☐ 9. Other _____

1.1.15 Practice Religion:

Before Trauma: ☐1. No ☐2. Yes After Trauma: ☐1. No ☐2. Yes

Notes:
☐ Expresses anger with God/Allah
☐ Do not express anger with God/ Allah
☐ Accept and satisfied with his destiny

1.1.16 Who lives with client in the household now? List name and relationship to client.

	Name	**Relationship**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

1.1.17 Current Living Situation:

☐ 1.Owns ☐2.Rents ☐3.Hotel ☐4. Shelter ☐ 5.Other _____

1.1.18 Living situation is:

☐ 1. Stable ☐ 2. Not Stable (Can you stay there as long as you want to? Do you feel secure?)

1.1.19 Do you feel safe at home and the community you live in? (Is there crime there? Risk of fire? Robbers?)

☐ 1. Very Safe **Error! Bookmark not defined.** 2. Safe **Error! Bookmark not defined. Error! Bookmark not defined.** 3. Not safe. **Error! Bookmark not defined.** 4. Dangerous

1.1.20 Do Housemates know about the torture history?

Error! Bookmark not defined. 1. Yes, they know about the torture.☐ 2. No, they do not know.☐ 3. Some know; some do not.

.☐ 4. Yes, but do not know details. ☐ 5. Not applicable.
Notes:

1.1.21 Chronology of Travel to the US:

	Country	**Date Left**	**Why did you leave?**
Country of Origin	_____	_____	_____
2nd country	_____	_____	_____
3rd country	_____	_____	_____
4th country	_____	_____	_____

1.1.22 Whereabouts of Immediate Family Members:

Relationship	Dead	Missing	Prison	Left behind	With client		
Mother	☐	☐	☐	☐	☐		
Father	☐	☐	☐	☐	☐		
Wife /Husband 1	☐	☐	☐	☐	☐		
Wife /Husband 2	☐	☐	☐	☐	☐		
Wife /Husband3	☐	☐	☐	☐	☐		
Wife /Husband 4	☐	☐	☐	☐	☐		
Siblings Age						Male	Female
Sibling1 _____	☐	☐	☐	☐	☐	☐	☐
Sibling2 _____	☐	☐	☐	☐	☐	☐	☐
Sibling3 _____	☐	☐	☐	☐	☐	☐	☐

Sibling4_____ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Sibling5 _____ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Sibling6 _____ ☐ ☐ ☐ ☐ ☐ ☐ ☐

{Children already accounted for on Page 2}

1.1.23 Survivor Status

☐ Primary Survivor ☐ Secondary Survivor

1.1.24 Ethnic Group Affiliation: _____

SOCIAL SECURITY NUMBER: _____

Does client have a Georgia driver's license? Yes No (circle one)

1.2 TRAUMA HISTORY

1.2.1 Reasons for Persecution (Mark all that apply.) Write the reason for the persecution in the client's own words in this box.

☐ 1. Politics

☐ 2. Religion

☐ 3. Ethnicity

☐ 4. Humanitarian Work

☐ 5. Relative of Another Victim

☐ 6. Gender

☐ 7. Domestic Violence

☐ 8. Civil War

☐ 9. Refused to Cooperate

☐ 10. Spoke out Against Government

☐ 11. Genocide

_____ HURIDOCS code(s) for victim characteristics.

1.2.2 Family Members Affected by the Torture:

	Harassed	Imprisoned	Tortured	Killed	Disappeared	Sev. emot. hurt
1. Spouse/ Sig. Other	☐	☐	☐	☐	☐	☐
2. Children	☐	☐	☐	☐	☐	☐
3. Siblings	☐	☐	☐	☐	☐	☐
4. Aunts/ Uncles/ Cousins	☐	☐	☐	☐	☐	☐
5. Parents/ Grand Parents	☐	☐	☐	☐	☐	☐
6. Friends/ Acquaintances	☐	☐	☐	☐	☐	☐

NOTE:
The Torture Documentation should be a complete representation of the client's best recollection of the torture experience. A personal statement should be attached to this list of abuses and deprivations.

TORTURE DOCUMENTATION

1.2.3 Torture Story: What happened in Client's words?

	Event 1: Country	Event 2: Country
Dates from & to	From_____To _____ Date Date	From_____ to _____ Date Date
Place where event occurred, include city if known	1. Police station 2. Military camp 3.Jail/Detention 4.In a car 5.Home 6.Street/Road 7.Unknown place 8.Work 9.Healthcare facility 10.School Other:	1. Police station 2. Military camp 3.Jail/Detention 4.In a car 5.Home 6.Street/Road 7.Unknown place 8.Work 9.Healthcare facility 10.School Other:
Duration: (hours/days)		
Beaten # (Object used)		
Stabbed (Object used)		
Suspended 1.Upside down 2.Upright		
Gunshot		
Electric shocks		
Shackled, Handcuffed		
Smothered		
Burned (how)		
Forced Experiments		
Crushing Injury		
Amputations (which)		
Stretch body parts (which)		
Exposure to: 1.Heat 2.Cold 3.Chemicals 4.Drugs	_____ _____ _____ _____	_____ _____ _____ _____
Walk on knees		
Machines		
Forced labor (how)		

1.2.5 Forms of Psychological Abuse that Client Endured:

	Event 1	Event 2
See dead bodies		
See/Hear Torture		
See Rapes		
See Killings (family?)		
Forced to Accuse Others		
Forced to Confess		
Re-education		
Threatened		
Threatened Relatives		
Threat of Death		
See Mock Executions		
False Accusations		
Constant Noises		
Exposed to Lights		
Solitary Confinement		
Had a Trial		
Heard Formal Accusations		
Forced to Sign Papers		
Forced to Commit Atrocities		

1.2.6 List other traumatic life experiences (such as natural disasters, death of parents, domestic violence, and traumas experienced before or after the torture or now).

a. Before the torture:
   _____
b. After the torture:
   _____
c. Now:
   _____

1.2.7 Forms of Sexual Abuse that Client Endured:

	Event 1	Event 2
Rape 1. Anal 2.Vaginal	_____ _____	_____ _____
Was nude		
Sexual Humiliation		
Genital Trauma		

Sexual Instrumentation		
Beatings on genitals		
Electrodes		
Suspended by testicles		
Penis intrusion		

1.2.8 Prison Conditions that Client Endured:

	Event 1	**Event 2**
DEPRIVED OF:		
Water		
Light		
Toilet		
Bath		
Sleep		
Medical Care		
Communication		
Food		
CONDITIONS		
Bed or Mattress		
Climate control		
Able to stand/sit		
Window		
Cellmates (number)		
RELEASED AFTER:		
Will of Torturer		
Cooperation with Torturer		
Religious Org		
Human Rights Organization		
Attorney		
Relatives		
Friends		
Foreign Gov't		
Government Official		
Escaped		
Bribed Guards		

"How did you get out of prison?" *Please write the client's "escape story" in his/her own words.*

1.2.9 Did Client Receive Threats by:

☐ 1. Phone ☐ 2. Letters ☐ 3. E-Mail ☐ 4. In Person ☐ 5. Other

1.2.10 Where did Client Receive the Threats:

☐ 1. At home ☐ 2. On the street ☐ 3. At work ☐ 4. While detained ☐ 5. Other

1.2.11 Did the Client Experience Any of the Following?

	1. Yes	2. No
a. Lived in hiding, clandestinely, or underground?	☐	☐
b. Lost socioeconomic status?	☐	☐
c. Witnessed torture/rape/or murder of family?	☐	☐
d. Saw property destroyed?	☐	☐
e. Property Confiscated?	☐	☐
f. A health care professional helped torture him/her?	☐	☐
g. Stop going to school?	☐	☐
h. Lost job?	☐	☐
i. Prison torture?	☐	☐
j. Separated from all family members?	☐	☐
k. Forced to commit atrocities?	☐	☐

l. Long-term imprisonment?	☐	☐
m. Forced by authorities to leave the country?	☐	☐
n. Escaped the country to protect myself or family?	☐	☐
o. Other _____	☐	☐

1.2.12 Means of Survival:

☐ 1. Religious beliefs w/torturers ☐ 5. Luck, chance, fate ☐ 9. Cooperation
☐ 2. Family Support ☐ 6. Desire for revenge ☐ 10. Deception of torturers, tricks
☐ 3. Political beliefs ☐ 7. Humor, irony ☐ 11. Emotional distancing, dissoc
☐ 4. Will to survive ☐ 8. Cellmates ☐ 12. Physical exercise
☐ 13. Forgiveness. ☐ 14. Don't know ☐ 15. Community, party or tribe support.
☐ 16. Other _____

NEXT STEP: Comprehensive Strength and Need Assessment.

Client's Signature:_____

Case Manager/ Intake Person Signature:_____

Coordinator/ Supervisor Signature_____

APPENDIX B

Clinician-Administered PTSD Scale - 2

Below are some statements regarding how you may have felt and acted **during the past week.** Please circle the number for each statement to indicate how often that feeling or behavior has occurred.

Use the following scale:
0 =not at all 1 =only once/week 2= 2 or 3 times/week
3= 4 or 5 times/week 4 = about once/day 5= More than once/day

	not at all أبدا	Once during the week مرة خلال الاسبوع	2-3 times in the week 3-2 مرات في الاسبوع	4-5 times in the week 5-4 مرات في الاسبوع	about once a day مرة في اليوم	more than once a day أكثر من مرة في اليوم
1) Bad dreams or nightmares.						
2) Being especially alert or watchful, when there was actually no need to be on guard.						
3) Feeling in daze.						
4) Flashbacks of past unpleasant events.						
5) Unexpected or disturbing memories.						
6) Feeling as my emotions were shut down or blunted.						
7) Working hard to block out certain memories.						
8) Violent dream.						
9) Trying to avoid reminders of painful past events.						
10) Checking to see that I was safe.						
11) Jumping or being very frightened by sudden loud noises.						
12) Acting or feeling as if I were re-experiencing some painful past events						

13) Distress caused by reminders of a painful past event						
14) Efforts to avoid reminders of a painful past events.						
15) Feeling in danger.						
16) Feeling out of touch with my surrounding.						
17) Feeling that things going on around me were strange, unfamiliar or not quite real.						
18) Feeling as if I am watching myself from outside my body.						